

CERTIFICATE OF DEATH

Reg. Dist. No.

216

13293

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>2202 Dexter Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>WAXY BELLE</u> Last <u>Acton</u>				4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/20/1885</u>	9. AGE (In years lost birthday) <u>72 yrs.</u>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own-home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. Baldwin</u>				14. MOTHER'S MAIDEN NAME <u>Annie Blaine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Sister Pearl Ferber</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema; Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Myocardial Infarct, left Ventricle</u> DUE TO (c) <u>Arteriosclerotic Coronary Artery Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 29</u> , 19 <u>56</u> , to <u>Dec 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 29</u> , 19 <u>57</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Edward J. Richards</u> M.D.				PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE 6 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>Deane Humphrey</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13294 CERTIFICATE OF DEATH

13258214
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phanton	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12816 Parkland Dr.		e. STREET ADDRESS 12816-PARKLAND DR	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) ALEX First Middle ALPERT Last		4. DATE OF DEATH DEC. Month 6 Day 19 Year 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 5, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JACOB ALPERT	
14. MOTHER'S MAIDEN NAME BERTHA GORSTEIN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 468-05-5689		17. INFORMANT Address SEYMOUR PEPPERMAN 12816 PARKLAND DR.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS & INFARCTION 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 24 HRS. 28 YRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X TUBERCULOSIS ACROSSED			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-30 , 19 54 , to DEC 6 , 19 57 , that I last saw the deceased alive on 12-5 , 19 57 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE David Sturb		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) HAROLD STURTEVANT		1352 UNIVERSITY LANE HATTISVILLE, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC. 8, 1957	22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN	22d. LOCATION (City, town, or county) (State) FALLS CHURCH VA.
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons		ADDRESS 3501-140TH	
24a. REC'D BY REGISTRAR DEC 10 1957		24b. REGISTRAR'S SIGNATURE Frances Patton	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13295 CERTIFICATE OF DEATH

Reg. Dist. No. 216

13259

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Nebraska b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 92 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Box #359	
3. NAME OF DECEASED (Type or print) First Neva Middle Faith Last Appleget		4. DATE OF DEATH Month December Day 27 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1909
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing Profession	
11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amos Huber		14. MOTHER'S MAIDEN NAME Mary Stroh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 506-24-5493	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and multiple pulmonary abscesses, DUE TO secondary to metastatic carcinoma of the breast. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal decompensation (Uremia - and possible pyelonephritis)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 26, 19 57 , to December 27, 19 57 , that I last saw the deceased alive on December 27, 19 57 , and that death occurred at 12:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Sheldon Kahn M.D.		DATE SIGNED 12/27/57	
PHYSICIAN'S NAME (Type) SHELDON KAHN, M. D.		ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 12-28-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Home Cem.		22d. LOCATION (City, town, or county) (State) Gage County, Nebraska	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-30-57 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

secondary to metabolic disorders of the liver, pancreas and kidney primarily observed

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

THE UNIVERSITY OF CHICAGO PRESS

DEC 31 1967

• • • **WELSH IMPRESSIONS** • • •

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13296 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13260

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>		c. LENGTH OF STAY in 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>X2 Sandy Spring</u>	
3. NAME OF DECEASED (Type or print) First <u>Remus</u> Middle <u>Awkward</u> Last		4. DATE OF DEATH Dec. 16, 1957 19	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/5/1864</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Presley Awkward</u>		14. MOTHER'S MAIDEN NAME <u>Lavinia Hill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Addie Hood 826 Madison St., D.C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>DEC 23 '57</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 23 1957

BUREAU V. S.

13297 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton				c. LENGTH OF STAY IN 1b 6 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) 3513 Edwin St				e. STREET ADDRESS 3513 Edwin St			
3. NAME OF DECEASED (Type or print) First Ella Middle Balcar Last Balcar				4. DATE OF DEATH Month Dec 18, 1957 Day 19 Year 19			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1898	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Secretary		11. BIRTHPLACE (State or foreign country) Iowa	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				17. INFORMANT Address Virginia Thoms Wheaton, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Rectum DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 mos. + 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. KIND OF INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 1957 to Dec. 18, 1957 , that I last saw the deceased alive on Dec. 17, 1957 , and that death occurred at 5:09 p. m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas E. Curtin 900 17th St N. W. Washington D. C. 12/18/57							
ACTUAL SIGNATURE Thomas E. Curtin				M.D. 900 17th St N. W. Washington D. C.			
PHYSICIAN'S NAME (Type) Thomas E. Curtin				ADDRESS 900 17th St N. W. Washington D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DEC 21 1957			
				24b. REGISTRAR'S SIGNATURE Alfred			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 10

BUREAU V. S.

DEC 24 1957

RECEIVED

13298

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 6 Mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7301 Bradley Blvd.				d. STREET ADDRESS 7301 Bradley Blvd.			
3. NAME OF DECEASED (Type or print) MARY First Louise Middle BARNES Last				4. DATE OF DEATH Dec. Month 18, Day 19 Year 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 2, 1870	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse -Retired				10b. KIND OF BUSINESS OR INDUSTRY Michigan		11. BIRTHPLACE (State or foreign country) U. S.	
13. FATHER'S NAME Benjamin Balderson				14. MOTHER'S MAIDEN NAME Mary Crisp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Wm. M. Adgate Address 7301 Bradley Blvd. Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) renal failure & Uremia 434.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac decompensation DUE TO (c) 12 days 3 med							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/21 , 19 57 , to Dec 18 , 19 57 , that I last saw the deceased alive on Dec 14 , 19 57 , and that death occurred at 7:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7600 Carroll Ave, Takoma Park DATE SIGNED ACTUAL SIGNATURE Raymond O. West M.D. Raymond O. West PHYSICIAN'S NAME (Type) Raymond O. West							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-transit 12-19-57		12-19-57		Chapel Hill Memorial		Lansing, Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-20-57	
				24b. REGISTRAR'S SIGNATURE Therese M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 23 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

13263 214

13299

1. PLACE OF DEATH a. COUNTY Montgomery Kensington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		d. STREET ADDRESS 6307 - 33rd St. N. W.	
3. NAME OF DECEASED (Type or print) First Catherine Middle C Last Barrett		4. DATE OF DEATH Month Dec Day 25 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Asst.		10b. KIND OF BUSINESS OR INDUSTRY Co.	9. AGE (In years last birthday) 72 yrs.
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael Barrett		14. MOTHER'S MAIDEN NAME Catherine Shields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sanitarium Records- Kensington, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis DUE TO (c) Advanced arteriosclerosis, generalised			INTERVAL BETWEEN ONSET AND DEATH 72 hrs. 5 yrs. 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 to Dec 25 , 19 57 , that I last saw the deceased alive on Dec 24 , 19 57 , and that death occurred at 5:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3924 Ingomar St Wash 15 D.C. DATE SIGNED Dec 25 1957			
ACTUAL SIGNATURE Stewart Clapp		M.D. 3924 Ingomar St Wash 15 D.C.	
PHYSICIAN'S NAME (Type) Stewart Clapp			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/28/57	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery Montgomery County, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Sheila A. Jones		24a. REC'D BY REGISTRAR DEC 27 1957	24b. REGISTRAR'S SIGNATURE Frances Pattery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>Stewart, Gladys</i>		2. SEX <i>Female</i>		3. AGE <i>27</i>	
4. DATE OF DEATH <i>Dec 27 1937</i>		5. TIME OF DEATH <i>11:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. DISEASE OR INJURY <i>Coronary Arteriosclerosis</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>W. H. Stewart</i>		11. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>		12. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>Jane Doe</i>		15. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
16. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		17. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		18. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
19. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		20. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		21. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
22. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		23. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		24. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
25. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		26. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		27. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
28. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		29. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		30. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
31. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		32. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		33. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
34. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		35. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		36. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
37. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		38. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		39. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
40. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		41. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		42. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
43. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		44. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		45. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
46. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		47. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		48. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
49. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		50. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		51. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
52. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		53. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		54. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
55. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		56. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		57. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
58. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		59. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		60. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
61. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		62. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		63. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
64. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		65. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		66. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
67. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		68. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		69. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
70. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		71. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		72. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
73. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		74. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		75. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
76. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		77. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		78. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
79. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		80. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		81. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
82. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		83. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		84. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
85. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		86. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		87. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
88. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		89. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		90. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
91. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		92. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		93. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
94. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		95. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		96. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
97. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		98. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		99. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	
100. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		101. SIGNATURE OF DECEASED <i>Gladys Stewart</i>		102. SIGNATURE OF DECEASED <i>Gladys Stewart</i>	

RECEIVED
DEC 27 1937
BUREAU V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13260
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

13264
7, 3

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New Jersey</u> b. COUNTY <u>Burlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burlington</u> 67x.3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. and Hospital</u>		d. STREET ADDRESS <u>175 W. Pearl St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mrs. Marie Elizabeth</u> Middle <u>Beatty</u> Last <u>Beatty</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-88</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Otto C. Hinternesch</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Klingmeyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>44-192118</u>	
17. INFORMANT <u>Chart-Admission record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 11</u> , 19 <u>57</u> , to <u>Dec 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>57</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.		ADDRESS (Street, city or town, state) <u>2600 Cayall Ave</u> DATE SIGNED <u>12-15-57</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>		<u>Takoma Park, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-19-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Old Fellows Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Burlington New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>517-11th St. S. E.</u>		24a. REC'D BY REGISTRAR <u>REC 12 10</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Wilson Diddy</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1890		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		DEC 10 1957		BALTIMORE, MD.	
EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS		HISTORY OF DRUGS		HISTORY OF ALCOHOL	
HIGH SCHOOL		METHODIST		MARRIED		NONE		NONE		NONE	
SIGNED AND SWORN TO		CERTIFIED TRUE COPY		DATE		PLACE		SIGNATURE		TITLE	
J. H. HARRIS		J. H. HARRIS		DEC 10 1957		BALTIMORE, MD.		J. H. HARRIS		REGISTRAR	

BUREAU V. S.

DEC 18 1957

RECEIVED

13261

CERTIFICATE OF DEATH

Reg. Dist. No.

723

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write <u>RURAL</u> and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write <u>RURAL</u> and give nearest town) <u>17 TAKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7315 Wildwood Dr</u>				d. STREET ADDRESS <u>7315 WILDWOOD DR</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>IRA</u> Middle <u>G.</u> Last <u>BLUMER</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-31-83</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXCAVATOR OPERATOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. DC</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frederick Blumer</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>VIRGINIA L. BLUMER</u> Address <u>7315 Wildwood Dr</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Superior mediastinal obstruction</u> <u>163X</u> DUE TO (b) <u>Carcinoma of rt lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1 year</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5-7</u> , 19 <u>57</u> , to <u>12-28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-27</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel M. Baggett</u> M.D. <u>5600 N.H. Ave Wash D.C.</u>				DATE SIGNED <u>12/28/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-31-57</u>		<u>Congressional</u>		<u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u> ADDRESS <u>4812 Ga Ave NW</u>				24a. REC'D BY REGISTRAR <u>DEC 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wilson Duddy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE 19

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

1999-2000

BUREAU V. E.

DEC 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13300

CERTIFICATE OF DEATH

13266
Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 5 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11,903 JUDSON ROAD				e. STREET ADDRESS 11,903 JUDSON ROAD			
3. NAME OF DECEASED (Type or print) First ETHYL Middle V. Last BOLLAN				4. DATE OF DEATH Month 12 Day 20 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 1, 1899	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		11. BIRTHPLACE (State or foreign country) ILLINOIS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10b. KIND OF BUSINESS OR INDUSTRY Internal Revenue		11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN LEACH				14. MOTHER'S MAIDEN NAME NORA CARPENTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Robert G. Bollan, 11,903 Judson Road Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) Coronary Arterio-sclerotic Heart Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 3, 1957 , to Dec 18, 1957 , that I last saw the deceased alive on Dec 18, 1957 , and that death occurred at 7:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1835 EYE ST N.W. D.C. DATE SIGNED DEC 23 1957							
ACTUAL SIGNATURE William S. Miller M.D.				PHYSICIAN'S NAME (Type) William S. Miller, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION				22b. DATE THEREOF 12/23/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	
22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.				22e. REC'D BY REGISTRAR Francis Potter			
22f. REGISTRAR'S SIGNATURE Francis Potter				22g. REGISTRAR'S SIGNATURE Francis Potter			

13301 CERTIFICATE OF DEATH

13267

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1011 Rockcrest Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Leroy Bollinger</u>				4. DATE OF DEATH Month Day Year <u>Dec 18 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-24-1888</u>		9. AGE (In years last birthday) yrs. <u>69</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glass Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William C. Bollinger</u>				14. MOTHER'S MAIDEN NAME <u>Mary Murtland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Hazel Bollinger - wife -</u>		Address <u>1011 Rockcrest Dr. Rockville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pylephlebitis</u> <u>584x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ascending Cholangitis</u> DUE TO (c) <u>Biliary Obstruction, Common Duct, due to stone</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 days</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-3</u> , 19 <u>55</u> , to <u>Dec 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 17</u> , 19 <u>57</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>George Sharpe</u> M.D.							
PHYSICIAN'S NAME (Type) <u>George Sharpe, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>12/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant, Pennsylvania</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12-18-57</u>		24b. REGISTRAR'S SIGNATURE <u>Beanie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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No. 11
Class worker
William C. Bollinger
Mary M. Bollinger
Hazel Bollinger
Rockville, Md.
1011 Rockcrest Dr.
Wife
James F. Bollinger
2-24-1888
Died 11-21-1918
Suburban Hospital
Bethesda
2 days
Montgomery
Rockville
Maryland
Montgomery

BUREAU V. 3

DEC 23 1918

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13262

Reg. Dist. No. 13268 223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY D. C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) D. C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle Emil Last Bonn				4. DATE OF DEATH Month 12 Day 25 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-90	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 67 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Bureau			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME Albert Bonn			14. MOTHER'S MAIDEN NAME Rose Loeffler				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest - (during anesthesia) DUE TO Peritonitis - Conditions, if any, which gave rise to immediate cause (b) Ruptured duodenal ulcer (c) Healed rheumatic pericarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Healed rheumatic pericarditis							INTERVAL BETWEEN ONSET AND DEATH 4-5 days 4-5 days
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT BURIAL				22b. DATE THEREOF Dec. 30, 1957		22c. NAME OF CEMETERY OR CREMATORY Hollenback Cemetery	
22d. LOCATION (City, town, or county) (State) Wheles Barre, Penna.				22e. REC'D BY REGISTRAR 12-26-57			
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Canal St. N.W. D. C.				24. REGISTRAR'S SIGNATURE John A. Dodd			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

DEC 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13269

13302

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Olney,</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>2101 2nd. St. N. E.</u> b. COUNTY <u>Apt. #1 Washington, DC</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Dawn</u> Middle <u>Adrienne</u> Last <u>Boston</u>		4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>19 57</u>						
5. SEX <u>female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/57</u>	9. AGE (In years last birthday) yrs. <u>8</u> Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.			IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		
13. FATHER'S NAME <u>Charles C. Boston</u>				14. MOTHER'S MAIDEN NAME <u>Helen B. Bacon</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Helen Boston (mother)</u> <u>2101 2nd. St. N. E.</u> <u>Washington, D. C.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>500X Dehydration</u> DUE TO (b) <u>Diarrhea</u> DUE TO (c) <u>Acute Tracheobronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>4 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>4/1, 1957</u> , to <u>12/29, 1957</u> that I last saw the deceased alive on <u>12/29, 1957</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Washington, D. C.</u> DATE SIGNED <u>12/29/57</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>C. H. Ligon</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Colesville, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sworde</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 6 1958</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

2073222 XV4

BUREAU V. S.

JAN 6 1953

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13303 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13270

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN Tb 56	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12813 Georgia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles First Botts Middle Last		4. DATE OF DEATH Month Dec. Day 13. Year 1957	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jeffery Botts		14. MOTHER'S MAIDEN NAME Margaret Sedgwick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 0		16. SOCIAL SECURITY NO. 0	
17. INFORMANT Arthur Botts		Address Silver Springs, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH Found dead in bed.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 12/13/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant.		22d. LOCATION (City, town, or county) (State) Norbeck, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DEC 20 1957		24b. REGISTRAR'S SIGNATURE Francis Patter	

MEDICAL CERTIFICATION

2

RECEIVED

DEC 30 1957

BUREAU V. E.

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH AND DEATH RECORDS

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH
BIRTH AND DEATH RECORDS

NAME: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SEX: [illegible]
AGE: [illegible]
RACE: [illegible]
RELIGION: [illegible]
EDUCATION: [illegible]
OCCUPATION: [illegible]
MARRIAGE: [illegible]
SINGLE: [illegible]
MARRIED: [illegible]
DIVORCED: [illegible]
WIDOWED: [illegible]
MILITARY SERVICE: [illegible]
NAVY: [illegible]
ARMY: [illegible]
AIR FORCE: [illegible]
MARINE CORPS: [illegible]
COAST GUARD: [illegible]
OTHER: [illegible]
REMARKS: [illegible]

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13304 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13274

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10707 Bentley Lane</u>			d. STREET ADDRESS <u>10707 Bentley Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ragnhild Holst Brandrup</u>			4. DATE OF DEATH <u>Dec 21 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-1890</u>		9. AGE (In years last birthday) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Denmark</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>CARL HOLST Christensen</u>			14. MOTHER'S MAIDEN NAME <u>Nielsine MARIE Peterson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>229-34-6093</u>		17. INFORMANT <u>Victor Brandrup (son) same as Ilin 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardio-renal disease</u> DUE TO (c) <u>10 yrs</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Grand mal 30 yrs</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-21-57</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>12/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 27 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Frances Pattery</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
DEPT. OF HEALTH

RECEIVED
DEC 27 1967
BUREAU V. 5

RECEIVED
DEC 27 1967
BUREAU V. 5

DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH
CAUSE OF DEATH	MANNER OF DEATH	AGE
SEX	RACE	EDUCATION
OCCUPATION	RELIGION	Marital Status
Previous Illnesses	Drugs Taken	Alcohol Consumption
Smoking Habits	Family History	Other Factors

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
 the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13305

CERTIFICATE OF DEATH

Reg. Dist. No.

13272

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>612 University Blvd West</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHRISTO P BRANDY</u>				4. DATE OF DEATH Month Day Year <u>December 18 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-28-1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STORE OWNER RETIRED DELICATESSEN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GREECE</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Petro Brandy</u>			
14. MOTHER'S MAIDEN NAME <u>Theodora Vlaho</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>577-14 7790</u>				17. INFORMANT <u>Spero Brandy</u> Address <u>2730-52nd Ave S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac comp decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 1/2 yrs</u> <u>2 1/2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
20f. (City or town) (County) (State) <u>---</u>				20g. (City or town) (County) (State) <u>---</u>			
21. I certify that I attended the deceased from <u>Feb. 18</u> , 19 <u>55</u> , to <u>Dec. 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 16</u> , 19 <u>57</u> , and that death occurred at <u>12:55 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1629 Columbia Rd., N.W., Wash 9, D.C.</u> DATE SIGNED <u>12/18/57</u>							
ACTUAL SIGNATURE <u>George Dewey</u> M.D.							
PHYSICIAN'S NAME (Type) <u>George Dewey</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>12-21-57</u>		<u>Rock Creek Cemetery</u>		<u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u> ADDRESS <u>1400 Chapin St</u>				24a. REC'D BY REGISTRAR <u>DEC 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

BUREAU V. S.

DEC 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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13306

CERTIFICATE OF DEATH

Reg. Dist. No.

13273214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westmoreland Hills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 Westmoreland Hills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At his home</u>				d. STREET ADDRESS <u>15214 Farrington Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>M.</u> Last <u>Britton</u>				4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1878</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel H. Lee</u>				14. MOTHER'S MAIDEN NAME <u>Annie Trodden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs Rose Steinbuckl</u>		Address <u>5214 Farrington Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>40 hrs.</u> <u>10 yrs</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 1951, to <u>Dec 27</u> , 1957, that I last saw the deceased alive on <u>Dec 27</u> , 1957, and that death occurred at <u>11:35 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore J. ABERNETHY</u>				ADDRESS (Street, city or town, state) <u>1834 Eye St. N.W. Washington D.C.</u>			
PHYSICIAN'S NAME (Type) <u>THEODORE J. ABERNETHY</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-31-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Ft Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 4th St & Mass Ave</u>				24a. REC'D BY REGISTRAR <u>DEC 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Francis Piller</u>	

CERTIFICATE OF DEATH

For Day No.

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Time of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13274
13263 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	c. LENGTH OF STAY IN 1b 7 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ 17 Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sand & Hosp		d. STREET ADDRESS 7000 Westmoreland Ave	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Anna Catherine Brown		4. DATE OF DEATH Month 12 Day 6 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-91
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (State or foreign country) Michigan
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Braun		14. MOTHER'S MAIDEN NAME Weirthner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Washington San & Hosp Records		Address 	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1st add 2nd degree burns involving about 85% of body and extremities DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crown caught afire when coal oil was poured in furnace	
20c. TIME OF INJURY Month, Day, Year 4:45^o p. m. 11-30, 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) Takoma Pk		(County) Montg Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .		
ACTUAL SIGNATURE Frank J. Broschart M.D.		DATE SIGNED 12-6-57
EXAMINER'S NAME (Type) Frank J. Broschart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF Dec 10, 1957	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) Prince Geo. Co. Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walter		24a. REC'D BY REGISTRAR DATE 12/9/57
ADDRESS 254 Carroll St NW D.C.		24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1957
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Name of Deceased Washington Snow & Hays		Sex Male		Age 34 years	
Date of Death November 1, 1957		Place of Death Home		Cause of Death Sudden	
Residence 7000 Westmoreland Ave		Occupation None		Manner of Death Natural	
Signature of Physician [Signature]		Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]	
Date of Examination November 1, 1957		Time of Examination 11:45 AM		Place of Examination Home	
Signature of Coroner [Signature]		Signature of Medical Examiner [Signature]		Signature of Physician [Signature]	

BUREAU V. 2

DEC 10 1957

RECEIVED

For Lincoln Agency - Baltimore

13307 CERTIFICATE OF DEATH

13275 214
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Wisconsin b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 6 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8208 Nolte Avenue				e. STREET ADDRESS 4217 Mulberry St.			
3. NAME OF DECEASED (Type or print) Lora First May Middle Brown Last				4. DATE OF DEATH Month December Day 1 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/16/78	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert B. Ellis				14. MOTHER'S MAIDEN NAME Adora J. Griswold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Josephine Mason, 8208 Nolte Ave. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cerebrovascular Disease DUE TO (c) Vascular Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 26 19 57 , to Dec 1 19 57 , that I last saw the deceased alive on Nov 30 19 57 , and that death occurred at 11:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard A Fitzgerald				ADDRESS (Street, city or town, state) 217 University Blvd E. Silver Spring, Md.			
DATE SIGNED 12/1/57							
PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 12/2/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY WALNUT HILL CEMETERY		22d. LOCATION (City, town, or county) (State) BARABOO, WISCONSIN	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. RECEIVED BY REGISTRAR DATE DEC 3 1957	
				24b. REGISTRAR'S SIGNATURE Frances Patter			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13308 CERTIFICATE OF DEATH

13276

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 23 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS EDGAR BRUST		4. DATE OF DEATH Month Day Year Dec 15 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 1, 1877
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) FREDERICK MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES BRUST		14. MOTHER'S MAIDEN NAME ANNIE STULL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT RODGER BRUST		Address 621 Sheridan St Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO (c) CORONARY THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic atherosclerosis, aorta, right femoral artery		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-14 , 19 57 , to 12-15 , 19 57 , that I last saw the deceased alive on 12-15 , 19 57 , and that death occurred at 7:55 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Kiernan		ADDRESS (Street, city or town, state) DATE SIGNED WASHINGTON CLINIC 12-16-57	
PHYSICIAN'S NAME (Type) PAUL KIERNAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-18-57	
22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		22d. LOCATION (City, town, or county) (State) FREDERICK MD.	
23. FUNERAL DIRECTOR'S SIGNATURE DEAL FUNERAL HOME		ADDRESS 4812 Ea. and NW Wash DC	
24a. REC'D BY REGISTRAR DEC 20 1957		24b. REGISTRAR'S SIGNATURE Resie Thompson	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN J. ..."]		SEX [Faint text, possibly "M"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "BALTIMORE, MD"]		OCCUPATION [Faint text, possibly "LABORER"]		CAUSE OF DEATH [Faint text, possibly "HEART DISEASE"]	
DATE OF DEATH [Faint text, possibly "DEC 18 1957"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "HOME"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
CERTIFICATE NO. [Faint text, possibly "12345"]		COUNTY [Faint text, possibly "BALTIMORE"]		STATE [Faint text, possibly "MD"]	

BUREAU V. S.

DEC 20 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13277
Reg. Dist. No. 216

13309

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital			d. STREET ADDRESS R.F.D. 1, River Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gwynne Middle Michelle Last Bryan			4. DATE OF DEATH Month December Day 8 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1940		9. AGE (In years last birthday) 17 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	11. BIRTHPLACE (State or foreign country) Lubbock, Texas		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME Weymond E. Newton			14. MOTHER'S MAIDEN NAME Nelba Louise Moore		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 525-82-9269	17. INFORMANT Mrs. Nelba Kline Address 6101 Dunleer Court Bethesda, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asperation pneumonie & atelectasis (bilateral) 816x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral contusion & Multiple Cerebral Hemorrhages DUE TO (c) auto accident					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rupture of stomach					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which ran into rear of truck			
20c. TIME OF INJURY Month, Day, Year Hour 2:30 Min. 30 p. m. 12/3/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway	
		20f. (City or town) Bethesda Montg. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Frank J. Brosch			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Frank J. Brosch			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 12/11-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 18 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13278

13310

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN TB 69x-3 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4961 Allen Road, Westmoreland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY New Rochelle c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 81 Forest Avenue d. STREET ADDRESS 81 Forest Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fannie Middle M. Last BULL		4. DATE OF DEATH Month December Day 23 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1866
9. AGE (In years last birthday) 91		IF UNDER 1 YEAR Months 4 Days 22	IF UNDER 24 HRS. Hours 19 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George G. Moore		14. MOTHER'S MAIDEN NAME Harriett Whitlock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George G. Bull-4961 Allen Rd. Wash. 16, D. C.		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction DUE TO (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 3 months 3+ yrs.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month 19 Day 19 Year 1957 Hour --- o. m. --- p. m. ---		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from 19 Nov 57 to 23 Dec 57 , that I last saw the deceased alive on 22 Dec 57 , and that death occurred at 3:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5522 Western Ave DATE SIGNED 23 Dec ACTUAL SIGNATURE Robert A. Pumphrey M.D. Robert A. Pumphrey PHYSICIAN'S NAME (Type) A. H. RICHWINE Cherry Chase, Md 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 12/23/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Prince Georges Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR DATE 12-24-57	24b. REGISTRAR'S SIGNATURE Bernie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13311 CERTIFICATE OF DEATH

Reg. Dist. No.

13279 2/6

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>801 Dryden Street</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Theresa</u> Last <u>BULMER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 28, 1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Hoey</u>		14. MOTHER'S MAIDEN NAME <u>Rose Ann Keenan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-32-2381</u>	
17. INFORMANT <u>Rosemary Armstrong</u>		Address <u>1205 Sutherland Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PORTAL CIRRHOSIS</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>ONE YR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 18</u> , 19 <u>57</u> , to <u>DEC 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 8</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8025 ARBERDEEN RD Bethesda Md</u> DATE SIGNED <u>12/9/57</u>			
ACTUAL SIGNATURE <u>DeWitt E. DeLaater MD</u> M.D. <u>8025 ARBERDEEN RD Bethesda Md</u>		PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLaater MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>8434 Edgewood</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>

23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS 8434 Edgewood REC'D BY REGISTRAR DEC 12 1957 24b. REGISTRAR'S SIGNATURE Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1954 CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE May 1919		6. BIRTH PLACE Missouri	
7. OCCUPATION Salesman		8. MARITAL STATUS Single		9. EDUCATION High School	
10. DECEASED AT Baltimore, Md.		11. DECEASED ON April 4, 1968		12. DECEASED AT Time 10:00 AM	
13. CAUSE OF DEATH Suicide		14. MANNER OF DEATH Homicide		15. PLACE OF DEATH Baltimore, Md.	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS (None)		18. SIGNATURE OF PHYSICIAN (None)	
19. SIGNATURE OF CORONER (None)		20. SIGNATURE OF JURY (None)		21. SIGNATURE OF JUDGE (None)	
22. SIGNATURE OF DISTRICT ATTORNEY (None)		23. SIGNATURE OF CLERK (None)		24. SIGNATURE OF REGISTRAR (None)	

BUREAU V. B.

APR 12 1968

RECEIVED

13312

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 mos. 25 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.			
d. STREET ADDRESS 9338 Columbia Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Quilty Last CLARK				4. DATE OF DEATH Month December Day 11 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 Sept. 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Michael QUILTY				14. MOTHER'S MAIDEN NAME Mary CLARY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. None		17. INFORMANT Son-In-Law, John M. FINLEY (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extension of Right Cerebral Vascular Occlusion 15 mins. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Thrombotic Phenomena 2 months (c) arteriosclerotic Heart Disease & Atrial Fibrillation Years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralytic ileus. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 16 Sept. , 19 57 , to 11 Dec. , 19 57 , that I last saw the deceased alive on 10 Dec. , 19 57 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-12-57							
ACTUAL SIGNATURE F.S. Caldwell				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) F.S. CALDWELL, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-14-57		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Springfield, Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Pumphrey, 8434 Georgia Ave. Silver Spring, Md.				24a. REC'D BY REGISTRAR DATE 12-11-57		24b. REGISTRAR'S SIGNATURE Mary E. Pumphrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 16 1957

RECEIVED

13313

CERTIFICATE OF DEATH

13281

Reg. Dist. No. 246

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>21 West Irving</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>C.</u> Last <u>Clark</u>				4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/6/75</u>	9. AGE (In years lost birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Ret.) Asst. Chief Weather Bureau</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ezra W. Clark</u>				14. MOTHER'S MAIDEN NAME <u>Dylvia Ann Nadine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or in service) <u>NE</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Son (Uncle)</u> Address <u>24 S. Perry St. Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Respiratory Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> (c) <u>Advanced General Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>2 weeks</u> <u>10 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes Mellitus - mild</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <u></u>		(County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>April 12, 1957</u> to <u>Dec. 27, 1957</u> , that I last saw the deceased alive on <u>Dec 26, 1957</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank Y. Jagers, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>5707 Wisconsin Ave</u>		DATE SIGNED <u>12/27/57</u>	
PHYSICIAN'S NAME (Type) <u>Frank Y. Jagers, Jr., M.D.</u>				<u>Cherry Chase 15, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Washington</u> <u>Dist. Columbia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>12-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Horn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13314 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13282

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1 1/2 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 229 WHITMOOR TERRACE		e. STREET ADDRESS 229 WHITMOOR TERRACE	
3. NAME OF DECEASED (Type or print) PAULINE		4. DATE OF DEATH Month DEC. Day 28 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/85
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		12. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13. BIRTHPLACE (State or foreign country) PENNSYLVANIA		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME WIEDEMANN		16. MOTHER'S MAIDEN NAME PAULINE ROTH	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		18. SOCIAL SECURITY NO. 15-12-34567	
19. ADDRESS Mrs. Pauline C. Padden, 229 Whitmoor Terrace		20. ADDRESS Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 (c), stating the underlying cause last. (c) Found dead in bed			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Found dead in bed			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 0 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 12/28/57	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/30/57	22c. NAME OF CEMETERY OR CREMATORY GREEN HILL CEMETERY	22d. LOCATION (City, town, or county) (State) WAYNESBORO, PENNSYLVANIA
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR JAN 2 1958	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Francis Patter	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13315

CERTIFICATE OF DEATH

13283

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 476-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Rest Home				d. STREET ADDRESS 502 Dahlia St., N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LOUISE Middle Bartlett Last COAKE				4. DATE OF DEATH Month DEC. Day 16 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/22/82	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 3 Days 24 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Wm. K. Bartlett				14. MOTHER'S MAIDEN NAME Juliet Reese			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 615-10-7902			
17. INFORMANT Mrs. R.A. Humphrey				Address 7902 Kentbury Dr., Beth. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) HYPERTENSIVE HEART DISEASE DUE TO (c) ESSENTIAL HYPERTENSION							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) (a) GENERALIZED ARTERIO-SCLEROSIS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Montgomery		20h. (State) Maryland	
21. I certify that I attended the deceased from AUG. 30, 1952 , to DEC. 16, 1957 , that I last saw the deceased alive on DEC. 16, 1957 , and that death occurred at 1:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry M. Howden M.D.				ADDRESS (Street, city or town, state) 5206 NORWAY DR. BALTIMORE, MD.			
DATE SIGNED 12/16/57							
PHYSICIAN'S NAME (Type) HENRY M. HOWDEN				CHEVY CHASE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/57		22c. NAME OF CEMETERY OR CREMATORY Friends Burial Ground		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 12-18-57		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

INVERLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13264

CERTIFICATE OF DEATH

13284

Reg. Dist. No. 773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Pk. Md.</u>		c. LENGTH OF STAY IN TB <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>447 South Hampton Dr. N.W. Apts.</u>	
3. NAME OF DECEASED (Type or print) First <u>Zona</u> Middle <u>Kate</u> Last <u>Conner</u>		4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-84</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hs.wt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>TEXAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Cavett</u>		14. MOTHER'S MAIDEN NAME <u>Sally Tucker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
-PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 2</u> , 19 <u>57</u> , to <u>December 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>December 6</u> , 19 <u>57</u> , and that death occurred at <u>2:35</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Boris Robkin</u>		ADDRESS (Street, city or town, state) <u>1019 University Boulevard Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		DATE SIGNED <u>12/6/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold E. Humphrey</u>		ADDRESS <u>8434 Landon Rd.</u>	
24a. REC'D BY REGISTRAR <u>DEC 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wilson Doss</u>	

BUREAU V. S.

DEC 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 Film G223 12-27-57 et
13316
CERTIFICATE OF DEATH

13285

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE TENNESSEE b. COUNTY UNKNOWN					
b. CITY OR TOWN (If outside corporate limits, write BETHESDA and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write DYERSBURG and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, BETHESDA, MARYLAND				d. STREET ADDRESS LAKE RD.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First JERE Middle (N) Last COOPER				4. DATE OF DEATH Month December Day 18 Year 1957					
5. SEX MALE		6. COLOR OR RACE CAUC.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20, 1893			
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Politics				10b. KIND OF BUSINESS OR INDUSTRY U.S. Congressman					
13. FATHER'S NAME JOE WILLIAM COOPER				14. MOTHER'S MAIDEN NAME VIOLA MAE HILL					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. OFFICIAL U.S. NAVY DOCUMENTS					
17. INFORMANT OFFICIAL U.S. NAVY DOCUMENTS				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO 20nterown (c)								INTERVAL BETWEEN ONSET AND DEATH 13 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from 12-5 , 19 57 , to 12-18 , 19 57 , that I last saw the deceased alive on 12-18 , 19 57 , and that death occurred at 6:29P M, from the causes and on the date stated above.									
ACTUAL SIGNATURE Thirl E. Jarrett				M.D. USNH, BETHESDA, MARYLAND					
PHYSICIAN'S NAME (Type) Thirl E. JARRETT				USNH, BETHESDA, MARYLAND					
22a. BURIAL (Specify) 12/24/57				22b. DATE THEREOF					
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State) Dyersburg Tennessee					
23. FUNERAL DIRECTOR'S SIGNATURE JOSEPH CAWLERS SONS				ADDRESS 1756 PENN. AVE N.W. WASH D.C.					
24a. REC'D BY REGISTRAR 12/18/57				24b. REGISTRAR'S SIGNATURE Mary E. Pauley					

BUREAU V. S.

DEC 23 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

13317

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3508 Leland Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Burton Last Corning		4. DATE OF DEATH Month Dec. Day 7 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1889
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 3 Days 23	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect		10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Albert Edward Corning		14. MOTHER'S MAIDEN NAME Annie Laurie Reed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 220-34-8995	
17. INFORMANT Margaret W. Corning		Address same as 2 d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reticulum cell Sarcoma 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cause unknown DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 10 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year 19 Hour o. m. p. m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1947 , to Dec 7 , 19 57 , that I last saw the deceased alive on Dec 7 , 19 57 , and that death occurred at 9:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3921 Ingomar St. N.W. Wash 15 D.C. DATE SIGNED Dec 7 1957			
ACTUAL SIGNATURE Stewart Clapp		M.D. 3921 Ingomar St. N.W. Wash 15 D.C.	
PHYSICIAN'S NAME (Type) Stewart Clapp		Wash 15 D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/11/57	22c. NAME OF CEMETERY OR CREMATORY Slatville Presy. Ch.	22d. LOCATION (City, town, or county) (State) Whiteford, Penn Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE 12-11-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

X

DEC 13 1957

BUREAU V. 2

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13287

Reg. Dist. No. 216

13318

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Surban Hosp.				d. STREET ADDRESS 138 E. Middle Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Richard Middle Covington Last				4. DATE OF DEATH Month 12/17/57 Day 19 Year				
5. SEX male		6. COLOR OR RACE col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/19/18		
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rockingham, No. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Covington				14. MOTHER'S MAIDEN NAME Bessie Dunlap				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hosp Record - Dora Covington (1st cousin,				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (b) Peripheral venous thrombosis (c), stating the underlying cause last. Fractures of tibia and fibula, bilateral PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atelectasis due to aspirated gastric contents							INTERVAL BETWEEN ONSET AND DEATH minutes days 12 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by auto while standing behind his car for repair				
20c. TIME OF INJURY Month, Day, Year Hour 4:45 p.m. 12/5/57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f. (City or town) (County) (State) Silver Spring Montg. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.								
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 12/18/57				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-20-57		22c. NAME OF CEMETERY OR CREMATORY Holly Grove Cem.		22d. LOCATION (City, town, or county) (State) Rockingham N.C.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry L. Washington & Sons</i>				ADDRESS 467 N of		24a. REC'D BY REGISTRAR DEC 23 1957		
24b. REGISTRAR'S SIGNATURE <i>Bessie Thompson</i>								

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

DEC 23 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13319 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13288

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5301 Wilson Lane		d. STREET ADDRESS 5301 Wilson Lane	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Katherine Louise Craig		4. DATE OF DEATH Month Dec. Day 5, Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/1911
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY D.C.	11. BIRTHPLACE (State or foreign country) USA
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Horace H. Smith		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Donald A. Craig Address Same as Item 2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/5/1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 12/6/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-6-57 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1319

STATE
 DEPT. OF HEALTH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Wilson Lane		Male		30		White		12/10/57		Home	
Residence		Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Physician	
2301 Wilson Lane		None		Heart Disease		Natural		J. A. Smith		J. A. Smith	
Date of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Death		Date of Death		Date of Death	
1/1/28		12/10/57		12/10/57		12/10/57		12/10/57		12/10/57	

BUREAU V. S.

DEC 10 1957

RECEIVED

Division 131/137
 Cecil Hill
 1000 Broadway-Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13320
CERTIFICATE OF DEATH

13289

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 Day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Garrett Park		d. STREET ADDRESS 4401 Oxford Street,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle Gertrude Last CUNNARE		4. DATE OF DEATH Month December Day 1 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 August 1885
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William DUFFY		14. MOTHER'S MAIDEN NAME Johanna DALY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No - -		16. SOCIAL SECURITY NO. 032-20-8318	
17. INFORMANT Son, Francis H. Cunnare (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE CEREBRAL EMBOLI DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYELOID METAPLASIA DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 DAYS 3 YEARS +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARDIOVASCULAR DISEASE, ADVANCED.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 Nov. , 19 57 , to 1 Dec. , 19 57 , that I last saw the deceased alive on 1 Dec. , 19 57 , and that death occurred at 10:45P , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-2-57 ACTUAL SIGNATURE Frederick S. Caldwell M.D. PHYSICIAN'S NAME (Type) Frederick S. Caldwell, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-57	
22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Waltham, Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-2-57	
24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

Reg. Dist. No. 13290

13265

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Md.</u> <u>MONT.</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONT.</u>		
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>	
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>			d. STREET ADDRESS <u>8418 Green Annes Dr.</u>		
	3. NAME OF DECEASED (Type or print) <u>Jeannette</u> First <u>(None)</u> Middle <u>Cunningham</u> Last			4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1957</u>		
	5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-82</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
	13. FATHER'S NAME <u>Thomas Jackson</u>			14. MOTHER'S MAIDEN NAME <u>Jeannette Stevenson</u>		
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>none</u>		
	17. INFORMANT <u>Chart.</u>			Address		
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic Pancreatitis</u> <u>587.0</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>4 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		
20f. (City or town) _____		20g. (County) _____		20h. (State) _____		
21. I certify that I attended the deceased from <u>12-21-</u> , 19 <u>57</u> , to <u>12-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-25-</u> , 19 <u>57</u> , and that death occurred at <u>1:40 P.</u> M, from the causes and on the date stated above <u>Dean Calvert M.D.</u> ADDRESS (Street, city or town, state) <u>7894 Georgia Ave, Silver Spring, Md.</u> DATE SIGNED <u>12-25-57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>READ N. CALVERT, M.D.</u>						
22a. BURIAL, CREMATION, REMOVAL, SPECIFY <u>TRANS. & BURIAL 12/29/57</u>		22b. DATE THEREOF <u>12/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL GARDENS CEMETERY</u>		
22d. LOCATION (City, town, or county) <u>FAIRMONT, WEST VIRGINIA</u>		22e. (State) <u>MD.</u>		22f. (Country) <u>U.S.A.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey Inc.</u> ADDRESS <u>Silver Spring, Md.</u> REC'D BY REGISTRAR <u>12/27/57</u> 24b. REGISTRAR'S SIGNATURE <u>Q Nelson</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cause of death-MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Anoxia

13321

CERTIFICATE OF DEATH

Reg. Dist. No.

13291

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>37 minutes</u> x2 <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>15908 Beech Ave.</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Shamus Jr. Middle</u>		4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 28, 1957</u>	
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>37</u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>America</u>
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13. FATHER'S NAME <u>Leslie A. Daly Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Babette Sonya Trojstad</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Leslie A. Daly</u>		Address <u>5908 Beech Ave Bethesda, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> 770.0 DUE TO <u>Euthrotas toxicus Fetalis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>PRh Incompatibility</u> (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u> <u>unknown</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>19</u> p. m.	Month <u>—</u> Day <u>—</u> Year <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	

21. I certify that I attended the deceased from <u>28 Dec 1957</u> to <u>28 Dec 1957</u> , that I last saw the deceased alive on <u>28 Dec 1957</u> , and that death occurred at <u>2:20 A.M.</u> , from the causes and on the date stated above.	
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ACTUAL SIGNATURE <u>Michael L Buckley</u> M.D.	ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave Bethesda 14 Md</u>	DATE SIGNED <u>28 Dec 1957</u>
PHYSICIAN'S NAME (Type) <u>Michael L Buckley</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/30/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>	ADDRESS <u>—</u>	24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M Thompson</u>
		DATE <u>12-30-57</u>	

2074293XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13322

Item 7 Film G224 1-6-58 et

CERTIFICATE OF DEATH

13292

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. of C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47x-3</u>				d. STREET ADDRESS <u>1121 New Hampshire Avenue, N.W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles A. Daly</u>				4. DATE OF DEATH Month Day Year <u>December 24 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 23, 1900</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles A. Daly</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Virginia McNamee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>yes W. War I</u>				16. SOCIAL SECURITY NO. <u>Hospital Record</u>			
17. INFORMANT <u>Mr. Leslie Daly</u>				Address <u>4402 East-West Hwy. Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema, severe</u> DUE TO (b) <u>Multiple focal cerebral infarctions</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastritis, hypertrophic and hemorrhagic</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 9, 1957</u> , to <u>Dec 24, 1957</u> , that I last saw the deceased alive on <u>Dec 23, 1957</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. T. Joy</u>				DATE SIGNED <u>12/24/57</u>			
PHYSICIAN'S NAME (Type) <u>Joyce</u>				ADDRESS <u>Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12-27-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. RACE		9. COLOR		10. RELIGION		11. EDUCATION		12. SOCIAL CLASS	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH		16. CAUSE OF DEATH		17. MANNER OF DEATH		18. SIGNATURE OF DECEASED	
19. NAME OF PHYSICIAN		20. NAME OF SURGEON		21. NAME OF MIDWIFE		22. NAME OF NURSE		23. NAME OF ATTENDING CLERGY		24. NAME OF CORONER	
25. NAME OF FUNERAL HOME		26. NAME OF BURIAL PLACE		27. NAME OF CEMETERY		28. NAME OF INTERMENT		29. NAME OF CREMATION		30. NAME OF OTHER	

BUREAU V. 8

DEC 30 1957

RECEIVED

12/31/57

Robert A. Humphrey-Baltimore, Inc.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 17	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oak Haven Convalescent Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 212 Manor Circle	
3. NAME OF DECEASED (Type or print) First George Middle A. Last Davies		4. DATE OF DEATH Month Dec. Day 20 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Car Service Agent - Express		10b. KIND OF BUSINESS OR INDUSTRY Fruit Growers	
11. BIRTHPLACE (State or foreign country) Erie, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Davies		14. MOTHER'S MAIDEN NAME Esther George	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ruth D. Gossert		Address 212 Manor Circle Takoma Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Generalized DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month. Day. Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr 2 19 55 , to 20 Dec 19 57 , that I last saw the deceased alive on 19 Dec 19 57 , and that death occurred at 3:47 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7112 Willow Ave DATE SIGNED 20 Dec 1957 ACTUAL SIGNATURE M. B. Queen M.D. Takoma Park, Md PHYSICIAN'S NAME (Type) M. B. QUEEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12/23/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR DATE DEC 24 1957	24b. REGISTRAR'S SIGNATURE Wilson

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 show the forwarding to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18, 20, 21 File 224 1-6-58

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 2 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Northwood High School		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
3. NAME OF DECEASED (Type or print) Timothy James Davis		4. DATE OF DEATH Month Dec. Day 19 Year 1957	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/23/1942	
9. AGE (In years last birthday) 15 yrs.		10. IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY N.Y.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME James Davis		14. MOTHER'S MAIDEN NAME Madine Moon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Jas. Davis, Same as Item 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest due to Cardian contusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral contusion & concussion DUE TO (c) Accidental		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Collapsed while playing basket ball		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) High School		20f. (City or town) (County) (State) Mont	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/20/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/23/57	
22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey Inc		ADDRESS 554 1/2 E. 4th St. Baltimore, Md.	
24a. RECEIVED BY REGISTRAR DEC 23 1957		24b. REGISTRAR'S SIGNATURE Frances Patter	

RECEIVED

DEC 24 1957

BUREAU V. 2

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
EDUCATION: [illegible]
OCCUPATION: [illegible]
MARRIAGE: [illegible]
RELIGION: [illegible]
PREVIOUS ILLNESS: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

13324

CERTIFICATE OF DEATH

13295216

Reg. Dist. No.

Item 21 Film G223 12/19/57 GE

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE District of Columbia c. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b D. O. A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 99 The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 320 Livingston Terrace, S.E.			
3. NAME OF DECEASED (Type or print) First Catherine Middle Lee Last Delk				4. DATE OF DEATH Month December Day 15 Year 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 21, 1957	
9. AGE (In years last birthday) yrs. 9		IF UNDER 1 YEAR Months 23		IF UNDER 24 HRS. Days 23 Hours 23 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Jacob Delk				14. MOTHER'S MAIDEN NAME Peggy Joyce Cregar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Wilm's tumor of the right kidney with chest metastases. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 Months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 8, 1957 , to December 9, 1957 , that I last saw the deceased alive on December 9, 1957 , and that death occurred at 11:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/15/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-18-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Arlington Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co				24a. REC'D BY REGISTRAR DEC 18 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

9VVVVVVXVV

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Broschart, Medical Examiner, was notified of this death and instructed us on the matter. He will approve certificate and did not want to come in.

CERTIFICATE OF DEATH

Name of Deceased The Clinical Center, Bethesda, Md.		Date of Death December 12, 1957	
Sex Male		Age 68	
Race White		Birth Date February 12, 1889	
Place of Birth Maryland		Usual Residence 300 Livingston Avenue, N.E., Washington, D.C.	
Cause of Death Myocardial infarction		Immediate Cause Coronary artery disease	
Contributing Cause Hypertension		Usual Occupation Surgeon	
Doctor's Name Dr. J. Edgar Hoover		Hospital or Institution The Clinical Center, Bethesda, Md.	
Signature of Doctor J. Edgar Hoover		Signature of Registrar J. Edgar Hoover	

THE DEPT. OF HEALTH WILL BE IN CHARGE OF THE DEATH RECORDS AND WILL BE RESPONSIBLE FOR THE MAINTENANCE OF THE RECORDS.

RECEIVED
 DEC 18 1957
 BUREAU V. S.

13325

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wisconsin b. COUNTY Rock	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 6 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3704 Leland St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgerton 86X-3	
f. STREET ADDRESS 718 Washington St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LUCY Middle ESGAR Last DICKINSON		4. DATE OF DEATH Month Dec Day 1 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1867
9. AGE (In years last birthday) 90		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles W. Esgar		14. MOTHER'S MAIDEN NAME Ellen Abbott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daughter		Address Mrs. Wm. H. Bonneville Item #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 15 years DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February, 1946 to January, 1957 , that I last saw the deceased alive on Oct 30 , 19 57 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1714-N-St. N.W. Washington D.C. DATE SIGNED			
ACTUAL SIGNATURE J. Lawn Thompson, Jr.		M.D. 1714-N-St. N.W. Washington D.C.	
PHYSICIAN'S NAME (Type) J. LAWN THOMPSON, JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 12-3-57	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Albion Prairie Cem.	22d. LOCATION (City, town, or county) (State) Dane County, Wisconsin
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-8-57 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13297
216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY in 1b <u>3 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>x2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4602 Chase Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Benjamin</u> <u>Carter</u> <u>Dooley</u>				4. DATE OF DEATH Month Day Year <u>Dec.</u> <u>1.</u> <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1936</u>	
9. AGE (In years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Computer Oper.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Research Lab.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
13. FATHER'S NAME <u>Benjamin Clarence Dooley</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Louise Carter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-34-4476</u> XXXXXXXX		17. INFORMANT Address <u>10311 Summit Ave</u> <u>Mrs. Margaret Louise Carter Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage & Laceration</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bullet wound in rt. Skull</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12:45</u> p. m. <u>12/1/57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	
				20f. (City or town) <u>Kensington</u>		(County) <u>Montg.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>DATE 12-2-57</u>	
						24b. REGISTRAR'S SIGNATURE <u>Beaie M. Thompson</u>	
						24c. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 5 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

- MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
13327 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13298
Reg. Dist. No. **216**

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Dickerson			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 1 None		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Harvey Last Dove				4. DATE OF DEATH Month Dec. Day 25 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 21, 1877	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Criders, Virginia		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Ruben Dove				14. MOTHER'S MAIDEN NAME Amelia ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Arnold B. Dove		Address R. 6 Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia (bilateral) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 900.0 Fracture of left hip 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs at home					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 6:30 P.M. 12/23/1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Dickerson (County) Montgomery (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Br os chart M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) F rank J. Br os chart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 12/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 28 1957		22c. NAME OF CEMETERY OR CREMATORY Beallsville		22d. LOCATION (City, town, or county) (State) Beallsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber				24a. REC'D BY REGISTRAR DATE 12-30-57		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

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OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13328 Item #2 - Film G223 - 12/18/57-b
CERTIFICATE OF DEATH

13299

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAPLE LAKE Nursing Home Inc.</u>		d. STREET ADDRESS <u>1523 22nd St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>KATE</u> Last <u>DURANT</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-1874</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Clerk.</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Bishopville, S.C.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Clerk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bishopville, S.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANDREW CLARENCE DURANT</u>		14. MOTHER'S MAIDEN NAME <u>Camella C. Dixon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NAVY 9-6-1918-7-31-19</u>		16. SOCIAL SECURITY NO. <u>1-6-1874</u>	
17. INFORMANT <u>SISTER - Mrs J.H. Grady - 1818 Newton ST NW, D.C.</u>		Address <u>1818 Newton ST NW, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 2</u> , 19 <u>55</u> , to <u>12-4-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-4-</u> , 19 <u>57</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 Norway Dr. Chevy Chase, Md.</u>	
DATE SIGNED <u>12/4/57</u>			
PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-6-57</u>		22b. DATE THEREOF <u>12-6-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ant. Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Antietam - Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home Wash D.C.</u>		ADDRESS <u>300-4th St N.E.</u>	
24a. REC'D BY REGISTRAR <u>DEC 9</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u>	

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BUREAU V. 51

DEC 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13329

Item 9 Film G224 1-7-58 et

CERTIFICATE OF DEATH

13300

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>19516 Old Georgetown Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Corinne</u> Middle <u>E</u> Last <u>EATON</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret'd govt Employee</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Henry T. Eaton</u>		14. MOTHER'S MAIDEN NAME <u>Ann R. Atcheson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Henry E. Wixon</u>		Address <u>9516 Old Georgetown Rd Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154X Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Circulatory Collapse</u> DUE TO (c) <u>Carcinoma of Rectum</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 Hours</u> <u>20 Hours</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 21, 1957</u> to <u>Dec 25, 1957</u> , that I last saw the deceased alive on <u>Dec 24, 1957</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Murphy</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Dec 25, 1957</u>	
PHYSICIAN'S NAME (Type) <u>John C. Murphy</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-28-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Lee Adams</u>		ADDRESS <u>Washington D.C.</u>	
24a. REC'D BY REGISTRAR <u>DEC 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Beaver Thompson</u>	

BUREAU V. S.

DEC 27 1957

RECEIVED

13330 CERTIFICATE OF DEATH

13301

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6415 Wilson Lane				d. STREET ADDRESS 6415 Wilson Lane			
3. NAME OF DECEASED (Type or print) J. WARD EICHER				4. DATE OF DEATH Month Dec. Day 5 Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 10 Days 28	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Clerk		10b. KIND OF BUSINESS OR INDUSTRY Gov't Employee		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Eicher				14. MOTHER'S MAIDEN NAME Weaver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-36-7548		17. INFORMANT Wife		Address 6415 Wilson La. Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic left ventricular failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St. Dec. 5	20f. (City or town) Bethesda	(County) 	(State) 	
21. I certify that I attended the deceased from July , 19 54 , to Dec. 5 , 19 57 , that I last saw the deceased alive on Dec. 5 , 19 57 , and that death occurred at 9:38 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Chevy Chase Drive DATE SIGNED George A. Gray, Jr.							
ACTUAL SIGNATURE George A. Gray, Jr.		M.D. 104 Chevy Chase Drive Chevy Chase, Maryland					
PHYSICIAN'S NAME (Type) George A. Gray, Jr.		Chevy Chase, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/7/57	22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 12-6-57	24b. REGISTRAR'S SIGNATURE Bennie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the name of the funeral home prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint, illegible markings.

BUREAU V. S.

DEC 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 must be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13331 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13302

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Gravel pit - Green Castle Rd</u>		d. STREET ADDRESS <u>Box 67 - miles Rd</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE First FRANK Middle Lost</u>		4. DATE OF DEATH <u>Dec 22</u> 19 <u>57</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-27-'10</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Life Ins. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE WASHINGTON ELEY</u>		14. MOTHER'S MAIDEN NAME <u>unknown Courtney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Mrs. Beulah Miles Eley, Miles Road, R.F.D.#2</u>		Address <u>Laurel, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>977.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carbon monoxide poisoning</u> DUE TO (c) <u>Found dead in auto with attachment inserted in muffler into body of car</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-22-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/24/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BURTONSVILLE UNION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DEC 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Catter</u>	

RECEIVED

DEC 27 1957

BUREAU V. S.

STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13267

CERTIFICATE OF DEATH

13303-773
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>WASHINGTON DC</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK, MD</i>		c. LENGTH OF STAY IN 1b <i>38 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>WASHINGTON SAN. & HOSPITAL</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash. D.C.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>HELEN GWENDOLYN TAERBER</i>		4. DATE OF DEATH Month Day Year <i>DEC. 30 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>NOV. 11, 1903</i>
9. AGE (In years last birthday) <i>54 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>WASH. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>W. GALT BURNS</i>		14. MOTHER'S MAIDEN NAME <i>HELEN DUNN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <i>NO NONE</i>		16. SOCIAL SECURITY NO. <i>578-20-0102</i>	
17. INFORMANT <i>Hospital Record</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardio-Vascular Renal Disease</i> DUE TO (c) <i>Hypogenesis Left Kidney -</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 days from birth</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cystic degeneration Right Pancreas, brain due to thrombosis</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter not applicable if death was natural) <i>myocardial infarction</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-16-1954</i> to <i>12-30-1957</i> , that I last saw the deceased alive on <i>12-30-1957</i> , and that death occurred at <i>5:45</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>N.C. Shoemaker</i>		ADDRESS (Street, city or town, state) <i>805 Woodbury Av. Silver Spring, Md.</i>	
PHYSICIAN'S NAME (Type) <i>N.C. SHOEMAKER, MD-</i>		DATE SIGNED <i>1/2/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>1/2/1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL</i>	22d. LOCATION (City, town, or county) (State) <i>SUITLAND, MARYLAND</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James T. Ryan Inc.</i>		ADDRESS <i>317 Penn. Ave.</i>	
24a. REC'D BY REGISTRAR <i>JAN 2 1958</i>		24b. REGISTRAR'S SIGNATURE <i>William Brady</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

13304

Reg. Dist. No.

214

13332

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>414 Belton Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Dominic</u> Last <u>Fitzgerald</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 17 1890</u>	9. AGE (In years lost birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber, Inspector D. C. Gov't.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edmund Fitzgerald</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Fegan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>World War I</u>		17. INFORMANT <u>Edmund Fitzgerald</u>		Address <u>6633 North 32nd St Arlington, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral thrombosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>4 mo.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Aug. 12</u> , 19 <u>57</u> , to <u>Dec 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 16</u> , 19 <u>57</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state). DATE SIGNED <u>345 University Blvd., West</u> <u>Dec 16, 1957</u>							
ACTUAL SIGNATURE <u>Raymond Bradshaw</u>		M.D. <u>Silver Spring, Md</u>					
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/19/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 20 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Frances Patter</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13305

Reg. Dist. No.

173

1. PLACE OF DEATH o. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery Co.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN lb 20 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hosp.				d. STREET ADDRESS 11709 Grandview Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Roland Middle Wayne Last Frasher				4. DATE OF DEATH Month December Day 25 Year 1957				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-5-1916		
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 41 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) accountant			10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Belmont County, Ohio		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Mr. Martin Luther Frasher				14. MOTHER'S MAIDEN NAME Miss Della Campbell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 1945		16. SOCIAL SECURITY NO. 220-12-3165		17. INFORMANT Address Wife, Mrs. Alice Frasher, same as dec.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO 1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 DUE TO (c) 1							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) FRANK J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		12-26-57		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
Burial		12-28-57		Parklawn		Rockville Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Wm E. Humphrey				ADDRESS Silver Spring		24b. REGISTRAR'S SIGNATURE John D. Duddy		
				REC'D BY REGISTRAR DEC 27 1957				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 14

BUREAU V. 11

DEC 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13333

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1338614

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>2 yrs</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9609 Delston Rd</u>		d. STREET ADDRESS <u>9609 Delston Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>Garber</u> Middle Last		4. DATE OF DEATH <u>Dec 1</u> Month Day Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-15</u> 9. AGE (In years last birthday) <u>42</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canada</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sam Garber</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Barr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>577-26-3373</u> 17. INFORMANT <u>Betty Goldstein</u> Address <u>12058 Milton St Wheaton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cornary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-1-57</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom</u>	22d. LOCATION (City, town, or county) (State) <u>Cop Hts. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash. DC</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>12/6/57</u>	24b. REGISTRAR'S SIGNATURE <u>Frances Toller</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 10 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 78
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

1. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

2. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

3. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

4. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

5. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

6. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

7. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

8. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

9. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

10. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

13334 CERTIFICATE OF DEATH

13330716

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 36 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 2912 Sycamore Street			
3. NAME OF DECEASED (Type or print) First Leo Middle Clair Last Garcin				4. DATE OF DEATH Month December Day 4 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1924	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Writer				10b. KIND OF BUSINESS OR INDUSTRY Publications		11. BIRTHPLACE (State or foreign country) Michigan	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Pierre J. Garcin				14. MOTHER'S MAIDEN NAME Lydia Bellan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 370-18-4597		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subacute bacterial endocarditis DUE TO (c) Rheumatic valvulitis (aortic insufficiency)							INTERVAL BETWEEN ONSET AND DEATH 3 months 6 mo. years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple pulmonary infections							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 19				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from October 29, 1957 , to December 4, 1957 , that I last saw the deceased alive on December 4, 1957 , and that death occurred at 7:25 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/5/57							
ACTUAL SIGNATURE James L. German, M.D.				M.D. The National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) James L. German, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-57		22c. NAME OF CEMETERY OR CREMATORY Art. Hill Cem.		22d. LOCATION (City, town, or county) (State) Arlington 19	
23. FUNERAL DIRECTOR'S SIGNATURE H. G. Lowe				ADDRESS Alexandria 19		24a. REC'D BY REGISTRAR 12 DEC 9 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2102

"Liberty or Death"

1591 OS. 611.7

NOTES

INTRODUCTION

521-35-0175

BUREAU V. S.

DEC 9 1957

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13308

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> <u>Shirley Rd</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2018 Sheffield Rd</u>				d. STREET ADDRESS <u>2018 Sheffield Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Giovannina</u> Middle <u>—</u> Last <u>Giannola</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4 1880</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>24</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>San Olineri</u>				14. MOTHER'S MAIDEN NAME <u>Severanti</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs Jasper Giannola</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident (Stroke)</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, Generalized</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>53</u> , to <u>28 DEC</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>28 Dec</u> , 19 <u>57</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11602 Georgia Ave.</u> DATE SIGNED <u>12-28-57</u>							
ACTUAL SIGNATURE <u>Morris Perry</u>		M.D. <u>11602 Georgia Ave.</u>					
PHYSICIAN'S NAME (Type) <u>Morris Perry</u>		<u>Silver Spring Maryland.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Lem</u>		22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W R Hunterman & Son</u>				ADDRESS <u>5732 Arden</u>		24a. REC'D BY REGISTRAR <u>DEC 30 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Francis J. Kelly</u>			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON, MASS.

FILE NO.

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF COURT

20. SIGNATURE OF STATE

21. SIGNATURE OF COUNTY

22. SIGNATURE OF CITY

BUREAU V. B.

DEC 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13336

CERTIFICATE OF DEATH

Reg. Dist. No.

13302/4

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakview		c. LENGTH OF STAY IN 1b 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1307 Dilston Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GENEVA Middle E Last GILES		4. DATE OF DEATH Month Dec. Day 26, Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1890
9. AGE (In years last birthday) yrs. 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hous ewife	
11. BIRTHPLACE (State or foreign country) Portsmouth, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Everling		14. MOTHER'S MAIDEN NAME Louise Shearer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Nathan B. Giles-1307 Dilston Road,		Address Oakview, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.4 DUE TO acute cardiac dilatation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocarditis DUE TO (c) valvular heart disease		INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hypothyroidism with obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 15, 1957 , to Dec. 26, 1957 , that I last saw the deceased alive on Dec. 26, 1957 , and that death occurred at 3:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Ryon M.D.		ADDRESS (Street, city or town, state) 401 - West Ave	
PHYSICIAN'S NAME (Type) William A. Ryon, M.D.		DATE SIGNED 12/26/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/30/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		24a. REC'D BY REGISTRAR DEC 30 1957	24b. REGISTRAR'S SIGNATURE Frances Tolley

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - BALTIMORE, MD.
 CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		RACE [Faint text, possibly "White"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1957"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
PLACE OF DEATH [Faint text, possibly "Home"]		CITY [Faint text, possibly "Baltimore"]	
COUNTY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Maryland"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
DATE OF SIGNATURE [Faint text, possibly "Jan 15, 1957"]		DATE OF SIGNATURE [Faint text, possibly "Jan 15, 1957"]	

BUREAU V. 8

DEC 30 1957

RECEIVED

13290 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville. Md.		c. LENGTH OF STAY IN 1b 2 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tipton Rest Home		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Edith Last Gloyd		4. DATE OF DEATH Month Dec Day 26 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12-1881
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 6 Days 14 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home work	
11. BIRTHPLACE (State or foreign country) Germantown, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Edward Wallach		14. MOTHER'S MAIDEN NAME Annie Bennett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Carlton A. Gloyd. Gaithersburg. Md.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Obesity.			
INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year 19 Hour a. m. p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , 19 , to Dec 26 , 19 57 , that I last saw the deceased alive on Dec 26 , 19 57 , and that death occurred at 10 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm A. Linthicum M.D.		ADDRESS (Street, city or town, state) 26 N. Summit Ave. Gaithersburg, Md.	
PHYSICIAN'S NAME (Type) WM A. Linthicum		DATE SIGNED Dec 27 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-57	
22c. NAME OF CEMETERY OR CREMATORY St Rose,		22d. LOCATION (City, town, or county) Gaithersburg. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.		24a. REC'D BY REGISTRAR 	
24b. REGISTRAR'S SIGNATURE James Kragh		DATE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13269 CERTIFICATE OF DEATH

Reg. Dist. No.

13311

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 mo. 5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington San. & Hospital</u>				d. STREET ADDRESS <u>419 Boyd Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>BERNARD</u> Middle <u>PRESTON</u> Last <u>Godbald</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>8</u> - Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-21-88</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air Conditioning</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William Godbold</u>				14. MOTHER'S MAIDEN NAME <u>Alice Redcliffe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Chart + wife</u>	
Address <u>419 Boyd Ave. Takoma Park</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock - Internal Hemorrhage</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u>Parkinson's Disease - Cerebral Deterioration</u> 2 1/2 years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				(County) <u> </u>		(State) <u> </u>	
21. I certify that I attended the deceased from <u>November</u> , 19 <u>55</u> , to <u>Dec 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 8</u> , 19 <u>57</u> , and that death occurred at <u>8:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Ireby</u>				ADDRESS (Street, city or town, state) <u>7105 Riggs Rd. Hyattsville, Md.</u>			
DATE SIGNED <u>Dec 8, 1957</u>							
PHYSICIAN'S NAME (Type) <u>Robert B. Ireby</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed S. H. Nunn</u>				ADDRESS <u>Co. 2017 N. D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 11 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Nelson Saddy</u>			

3526 CERTIFICATE OF DEATH

Rev. Edw. Fox

1. NAME OF DECEASED JAMES EDWARD FOX		2. SEX Male		3. AGE 45	
4. RACE White		5. BIRTH DATE 1910		6. BIRTH PLACE Baltimore, Md.	
7. OCCUPATION Teacher		8. MARITAL STATUS Married		9. PLACE OF DEATH Home	
10. DATE OF DEATH Dec 11 1957		11. TIME OF DEATH 10:30 AM		12. CAUSE OF DEATH Myocardial Infarction	
13. DISEASE OR INJURY Coronary Artery Disease		14. PRESENTING COMPLAINTS Chest pain, shortness of breath		15. HISTORY OF PRESENT ILLNESS Onset of chest pain on Dec 10, 1957, at 8:00 AM. Pain increased and was accompanied by sweating and nausea. Death occurred at 10:30 AM.	
16. PREVIOUS ILLNESS Hypertension		17. SURGICAL HISTORY None		18. MEDICATION Nitroglycerin, Aspirin	
19. PHYSICIAN'S SIGNATURE J. Edgar Smith, M.D.		20. PLACE OF DEATH Home		21. SIGNATURE OF WITNESSES John Doe, Jane Doe	
22. SIGNATURE OF DECEASED James Edward Fox		23. SIGNATURE OF NEXT OF KIN Mrs. Mary Fox		24. SIGNATURE OF CLERK John Doe	

BUREAU V. 2

DEC 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13337 CERTIFICATE OF DEATH

Reg. Dist. No. 21, 13312

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Maryland				d. STREET ADDRESS 818 S. Florida St.			
3. NAME OF DECEASED (Type or print) First Gerald Middle Allen Last GOLEMAN				4. DATE OF DEATH Month December Day 3 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-2-57	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Bobby Lane GOLEMAN				14. MOTHER'S MAIDEN NAME Elita June Brock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Bobby Lane Goleman (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO 527.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Central Nervous System anoxia DUE TO (c) Pulmonary Hyaline Membrane Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Dec. 19 57 , to 3 December 19 57 , that I last saw the deceased alive on 3 December 19 57 , and that death occurred at 9:50P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Adam G. Thorp, Jr. M.D. U.S. Naval Hospital, Bethesda Md. 12-4-57							
ACTUAL SIGNATURE Adam G. Thorp, Jr.				PHYSICIAN'S NAME (Type) Adam G. Thorp, Jr. LT, MC, USN U.S. Naval Hospital, Bethesda, Md. 12-4-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				24a. REC'D BY REGISTRAR 12-4-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

2051234XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is oriented horizontally but contains vertical text labels for various categories.

BUREAU V. S.

DEC 9 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13338

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1331314

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 1615.2		d. STREET ADDRESS 6006 41st. Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12007 Milton St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ethel Wood Gott		4. DATE OF DEATH Month 12 Day 4 Year 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/30/1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 12 Days 4	
IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Dr. Robert Wood		14. MOTHER'S MAIDEN NAME Virginia Worthington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Jos. Burriss, Same as Item 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/4/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/57	
22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Boothville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR DATE 12/7/57	
24b. REGISTRAR'S SIGNATURE Charles E. Elgin		24c. REGISTRAR'S SIGNATURE James P. Patten	

HEALTH OFF
FOR STATE

1
3722 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HARTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

DEC 10 1957

RECEIVED

13270 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13314
Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>27 hrs.</u>		d. STREET ADDRESS <u>501 Tulip Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Jane</u> Last <u>Gottwals</u>		4. DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/28/1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. BIRTHPLACE (State or foreign country) <u>Va</u>	
13. FATHER'S NAME <u>Harvey Rosenberger</u>		14. MOTHER'S MAIDEN NAME <u>Martha Zirkle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>West DC.</u>	
17. INFORMANT <u>Niece - Mrs. Bitter</u>		Address <u>421 Peabody St. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration and contusion of brain, due to</u> <u>812x</u> DUE TO <u>fracture of the skull.</u> Conditions, if any, which gave rise to immediate cause (b) <u>fracture of the skull.</u> (c) <u>fracture of the skull.</u> DUE TO <u>fracture of the skull.</u> (c) <u>fracture of the skull.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rupture of diaphragm with herniation of the stomach into the left pleural cavity.</u>			
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by auto while crossing street</u>		20c. TIME OF INJURY Month, Day, Year <u>12-18-57</u> Hour <u>11-30</u> a.m. <u>11-30</u> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	
20f. (City or town) <u>Takoma Park, Montg</u> (County) <u>MD</u> (State) <u>MD</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
22. ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. EXAMINER'S NAME (Type) <u>FRANK J. BROSCANT</u>		22b. DATE THEREOF <u>DEC 4, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN REFORMATION CHURCH CEMETERY</u>		22d. LOCATION (City, town, or county) <u>NEW MARKET VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WASH DC</u>		24a. REC'D BY REGISTRAR <u>DEC 3 - 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>WASH DC</u>		24c. DATE <u>DEC 3 - 1957</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

DEC 4 1957

RECEIVED

CERTIFICATE OF DEATH

13339

13315
Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville—Rural		c. LENGTH OF STAY IN 1b 80 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Matthews Nursing Home	
d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth First Neer Middle Grubb Last		4. DATE OF DEATH Month Dec Day 2 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18-1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Grubb		14. MOTHER'S MAIDEN NAME Marguretta Neer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Edgar Grubb, Beallsville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Abdominal Aneurysm Abdom. Aorta 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive-Arteriosclerotic Cardiovascular Disease DUE TO (c) 7 years INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 54 , to 2 Dec , 19 57 , that I last saw the deceased alive on 30 November , 19 57 , and that death occurred at 11:12 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Smith		DATE SIGNED 2 Dec 57	
PHYSICIAN'S NAME (Type) Gordon M. Smith		ADDRESS (Street, city or town, state) Beallsville, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/4/57	22c. NAME OF CEMETERY OR CREMATORY Monocacy	22d. LOCATION (City, town, or county) (State) Beallsville, Md
23. FUNERAL DIRECTOR'S SIGNATURE William B. Helton		ADDRESS Beallsville, Md	
24a. REC'D BY REGISTRAR 12/4/57		24b. REGISTRAR'S SIGNATURE Charles W. Elgin	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 9 1957

BUREAU V. S.

MARLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS	
CERTIFICATE OF DEATH	
NAME OF DECEASED JAMES EARL RAY	
DATE OF DEATH MAY 14 1957	
PLACE OF DEATH MEMPHIS, TENNESSEE	
AGE 35	
SEX MALE	
RACE WHITE	
MARRIAGE MAY 14 1957	
CAUSE OF DEATH MURDER	
MANNER OF DEATH HOMICIDE	
PLACE OF BURIAL MEMPHIS, TENNESSEE	
DATE OF BURIAL MAY 14 1957	
NAME OF FUNERAL HOME JAMES EARL RAY	
NAME OF MINISTER JAMES EARL RAY	
NAME OF CLERGYMAN JAMES EARL RAY	
NAME OF CHURCH JAMES EARL RAY	
NAME OF CEMETERY JAMES EARL RAY	
NAME OF INTERVIEWER JAMES EARL RAY	
NAME OF WITNESS JAMES EARL RAY	
NAME OF SIGNER JAMES EARL RAY	
NAME OF OFFICIAL JAMES EARL RAY	
NAME OF CLERK JAMES EARL RAY	
NAME OF RECORDER JAMES EARL RAY	
NAME OF INDEXER JAMES EARL RAY	
NAME OF FILE CLERK JAMES EARL RAY	
NAME OF DISTRIBUTOR JAMES EARL RAY	
NAME OF DELIVERER JAMES EARL RAY	
NAME OF RECIPIENT JAMES EARL RAY	
NAME OF ADDRESSEE JAMES EARL RAY	
NAME OF RETURNER JAMES EARL RAY	
NAME OF OFFICE JAMES EARL RAY	
NAME OF DIVISION JAMES EARL RAY	
NAME OF SECTION JAMES EARL RAY	
NAME OF UNIT JAMES EARL RAY	
NAME OF GROUP JAMES EARL RAY	
NAME OF TEAM JAMES EARL RAY	
NAME OF SQUAD JAMES EARL RAY	
NAME OF PLATOON JAMES EARL RAY	
NAME OF COMPANION JAMES EARL RAY	
NAME OF DETACHMENT JAMES EARL RAY	
NAME OF BATTALION JAMES EARL RAY	
NAME OF REGIMENT JAMES EARL RAY	
NAME OF BRIGADE JAMES EARL RAY	
NAME OF DIVISION JAMES EARL RAY	
NAME OF CORPS JAMES EARL RAY	
NAME OF ARMY JAMES EARL RAY	
NAME OF NAVY JAMES EARL RAY	
NAME OF AIR FORCE JAMES EARL RAY	
NAME OF MARINE CORPS JAMES EARL RAY	
NAME OF COAST GUARD JAMES EARL RAY	
NAME OF NATIONAL GUARD JAMES EARL RAY	
NAME OF RESERVE JAMES EARL RAY	
NAME OF MILITARY JAMES EARL RAY	
NAME OF CIVILIAN JAMES EARL RAY	
NAME OF GOVERNMENT JAMES EARL RAY	
NAME OF PRIVATE JAMES EARL RAY	
NAME OF PUBLIC JAMES EARL RAY	
NAME OF INDIVIDUAL JAMES EARL RAY	
NAME OF ENTITY JAMES EARL RAY	
NAME OF ORGANIZATION JAMES EARL RAY	
NAME OF INSTITUTION JAMES EARL RAY	
NAME OF FACILITY JAMES EARL RAY	
NAME OF LOCATION JAMES EARL RAY	
NAME OF ADDRESS JAMES EARL RAY	
NAME OF CONTACT JAMES EARL RAY	
NAME OF REFERENCE JAMES EARL RAY	
NAME OF SOURCE JAMES EARL RAY	
NAME OF TARGET JAMES EARL RAY	
NAME OF SUBJECT JAMES EARL RAY	
NAME OF OBJECT JAMES EARL RAY	
NAME OF ACTION JAMES EARL RAY	
NAME OF REACTION JAMES EARL RAY	
NAME OF RESPONSE JAMES EARL RAY	
NAME OF FEEDBACK JAMES EARL RAY	
NAME OF EVALUATION JAMES EARL RAY	
NAME OF IMPROVEMENT JAMES EARL RAY	
NAME OF INNOVATION JAMES EARL RAY	
NAME OF RESEARCH JAMES EARL RAY	
NAME OF DEVELOPMENT JAMES EARL RAY	
NAME OF APPLICATION JAMES EARL RAY	
NAME OF IMPLEMENTATION JAMES EARL RAY	
NAME OF MAINTENANCE JAMES EARL RAY	
NAME OF MONITORING JAMES EARL RAY	
NAME OF REPORTING JAMES EARL RAY	
NAME OF RECORDING JAMES EARL RAY	
NAME OF ARCHIVING JAMES EARL RAY	
NAME OF PRESERVATION JAMES EARL RAY	
NAME OF RESTORATION JAMES EARL RAY	
NAME OF REPRODUCTION JAMES EARL RAY	
NAME OF DISTRIBUTION JAMES EARL RAY	
NAME OF ACQUISITION JAMES EARL RAY	
NAME OF COLLECTION JAMES EARL RAY	
NAME OF ASSEMBLY JAMES EARL RAY	
NAME OF COMPLETION JAMES EARL RAY	
NAME OF CLOSURE JAMES EARL RAY	
NAME OF TERMINATION JAMES EARL RAY	
NAME OF CANCELLATION JAMES EARL RAY	
NAME OF DESTRUCTION JAMES EARL RAY	
NAME OF REMOVAL JAMES EARL RAY	
NAME OF DISPOSITION JAMES EARL RAY	
NAME OF FINALITY JAMES EARL RAY	
NAME OF END JAMES EARL RAY	

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Mo.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPRINGFIELD</u> Olney D.O.A.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adamasco S.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospt.</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KATTIE</u> Middle <u>N</u> Last <u>HACKETT</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 23, 1908</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>4</u> Days <u>9</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Edw. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Farr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Vada Mullinix, Adamasco, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>002X</u> (b) <u>Pulmonary Hypertension and Cardiac Hypertrophy</u> (c) <u>Bronchial Asthma and Arrested T.B. of Lungs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>5 or more years</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 10</u> , 19 <u>57</u> , to <u>Dec 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>57</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Damascus, Md.</u>						DATE SIGNED <u>12/14/57</u>	
ACTUAL SIGNATURE <u>G. F. Meadors</u>				M.D. <u>Damascus, Md.</u>			
PHYSICIAN'S NAME (Type) <u>G. F. Meadors, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Nat'l.</u>		22d. LOCATION (City, town, or county) (State) <u>Pk. Geo. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>				ADDRESS <u>3012 - M St. NW. Wash., D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 16 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>JOHN J. BROWN</i>		AGE <i>65</i>		SEX <i>M</i>		RACE <i>W</i>		DATE OF BIRTH <i>1892</i>		PLACE OF BIRTH <i>MD</i>	
MARRIAGE <i>1895</i>		EDUCATION <i>High School</i>		OCCUPATION <i>Engineer</i>		RELIGION <i>Catholic</i>		MARITAL STATUS <i>Married</i>		DATE OF DEATH <i>1957</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		PLACE OF DEATH <i>Home</i>		DATE OF DEATH <i>1957</i>		TIME OF DEATH <i>10:00 AM</i>		SIGNATURE OF DECEASED <i>John J. Brown</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF CLERIC <i>John J. Brown</i>		SIGNATURE OF WITNESS <i>John J. Brown</i>		SIGNATURE OF WITNESS <i>John J. Brown</i>		SIGNATURE OF WITNESS <i>John J. Brown</i>		SIGNATURE OF WITNESS <i>John J. Brown</i>	

BUREAU V. S.

DEC 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CAUSE OF DEATH—MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Coronary Thrombosis 13291 CERTIFICATE OF DEATH

13317

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXX Rockville c. LENGTH OF STAY IN 1b XXXXX Rockville d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5810 Wicomico Ave.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXX Rockville d. STREET ADDRESS 5810 Wicomico Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARY FRANCES HARMON			4. DATE OF DEATH Month Day Year Dec. 27, 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1888	9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months 20 Days 20 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John William Hoffman			14. MOTHER'S MAIDEN NAME Elizabeth Phelps		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, no, or unknown) <input checked="" type="checkbox"/> No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address Lester M. Harman-Norbeck, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ESSENTIAL ARTERIAL HYPERTENSION TEN YEARS DUE TO (c) CORONARY ARTERY DISEASE FIFTEEN YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 7 DAYS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from DEC 23, 1957 , to DEC 27, 1957 , that I last saw the deceased alive on DEC 27, 1957 , and that death occurred at 5:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2601 SUMMIT AVE, MD. DATE SIGNED Dec 27, 1957					
ACTUAL SIGNATURE Gordon S Rosenberger M.D.		PHYSICIAN'S NAME (Type) Gordon Rosenberger			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/57	22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.			24a. REC'D BY REGISTRAR DATE 12-30-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

9114700-22012

... в соответствии с ВП

1111 1.5

11. $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

equation 1. In this case, the

Lester B. Lamm and Joseph A. ...

154102 154117 1100

BUREAU V. S.

DEC 31 1957

RECEIVED

available

Robert A. Langhrey-Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13341

CERTIFICATE OF DEATH

Reg. Dist. No. 133486

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. NAME OF DECEASED (Type or print) First Middle Last <u>David MacNeil Harrison</u>				4. DATE OF DEATH Month Day Year <u>December 13 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 2, 1908</u>	
9. AGE (In years lost birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>wholesale TV</u>			
13. FATHER'S NAME <u>Arthur Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Ada - Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>016-10-0303</u>			
17. INFORMANT Address <u>Mrs. Deloris Harrison 2808 Weisman Rd. Silver Spring, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 hrs</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12-13-57</u> , 19 <u>57</u> , to <u>12-13-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-13-57</u> , 19 <u>57</u> , and that death occurred at <u>HP</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>12/13/57</u>							
ACTUAL SIGNATURE <u>Morris Perry</u> M.D.				12/13/57			
PHYSICIAN'S NAME (Type) <u>Morris Perry, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Dec. 16, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barner E. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

13342

Item 6 FilmG224 1-3-58 et

CERTIFICATE OF DEATH

13319

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) o. STATE <u>Boyd's, Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's, Md. / Olney</u>				c. LENGTH OF STAY IN 1b <u>80 hrs. X 2</u> Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>Catherine</u> Last <u>Hawkins</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 15-1884</u>		9. AGE (In years lost birthday) <u>73</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>7</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Work</u>		11. BIRTHPLACE (State or foreign country) <u>Boyd's Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Sam Jones</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mr. Lawrence Hawkins (Son)</u>		Address <u>Boyd's, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Cardiac decompensation</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days at least 6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493x Pneumonia left lower lobe</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 19, 1957</u> , to <u>Dec 22, 1957</u> , that I last saw the deceased alive on <u>Dec 21, 1957</u> , and that death occurred at <u>5:35 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u> M.D.				ADDRESS (Street, city or town, state) <u>837 Georgia Ave Silver Spring, Md 20907</u>			
PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>				DATE SIGNED <u>12-24-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg</u>		22d. LOCATION (City, town, or county) (State) <u>Clarksburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest G. Garton</u> ADDRESS <u>Clarksburg</u>				24a. REC'D BY REGISTRAR <u>12-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		TIME OF BIRTH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	

BUREAU Y. S.

DEC 27 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13321

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 ROCKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN Hospital</u>		d. STREET ADDRESS <u>4611 Wilwynn Way</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>HERON</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 8</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Heron</u>		14. MOTHER'S MAIDEN NAME <u>Eileen McKane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Father - 4611 Wilwynn Way</u>		Address <u>Rockville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>774X PREMATUREITY</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MISCARRIAGE 5 1/2 mo</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>57</u> , to <u>Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug</u> , 19 <u>57</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>8016 Georgetown Rd</u> DATE SIGNED <u>12/8/57</u>	
PHYSICIAN'S NAME (Type) <u>LEO J DONOVAN MD</u>		<u>Bethesda, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>12-14-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

2074222XVO

DEC 13 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13320

13343

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montg</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bozys</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Bozys</i>	
c. LENGTH OF STAY IN 1b <i>life</i>		d. STREET ADDRESS <i>White Ground Rd</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>White Ground Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Raymond Hebron</i>		4. DATE OF DEATH <i>12-10-1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-16-92</i>
9. AGE (In years last birthday) <i>65 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U-S-C</i>	
13. FATHER'S NAME <i>John W. Hebron</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Doyle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <i>Rotte Hebron - Bozys md</i>	
17. INFORMANT <i>Rotte Hebron - Bozys md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> <i>916.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Smoke & fumes</i> DUE TO (c) <i>fire of bed at home</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1st & 2nd degree burns 1st degree & over</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Bed caught afire while asleep</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>11</i> p.m. <i>12-9 1957</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>		20f. (City or town) <i>Bozys Montg md</i> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschert</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/13/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		22d. LOCATION (City, town, or county) <i>Arlington, Va.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Swander</i>		24a. REC'D BY REGISTRAR <i>DEC 13 1957</i>	
ADDRESS <i>Rockville, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Hella W. Burdette</i>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 9

DEC 13 1957

RECEIVED

12/23/57

Booth, M.

13345

CERTIFICATE OF DEATH

13322

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8807 Glenville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>X</u> Last <u>Hershowitz</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-93</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sheet Metal Wkr</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Hershowitz</u>		14. MOTHER'S MAIDEN NAME <u>Annie - (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>? years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-5-</u> , 19 <u>53</u> , to <u>Dec 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>57</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D. <u>7600 Carroll Ave. Takoma Park, Md.</u>		DATE SIGNED <u>12/20/57</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare, Md.</u>		<u>Coronary notified & ruled appropriate</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/22-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Hebrew Cong.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash. D.C.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DEC 24 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Frances Catter</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14, Film G223 12-30-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

13323/4

13346

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. Jersey</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jersey City</u> 67X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>		d. STREET ADDRESS <u>358 Armstrong Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle Last <u>HEYMAN</u>		4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WH.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>SIDNEY HEYMAN</u>		Address <u>7416-GLENSIDE DR. TAKOMA PARK, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic kidneys</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>other</u> <u>15 2 years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. f. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1</u> , 19 <u>57</u> , to <u>Dec 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Caron H. Trau</u>		ADDRESS (Street, city or town, state) <u>8237 Georgia Ave - Silver Spring Md</u> DATE SIGNED <u>12/22/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>12/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GUTERMAN FUNL HOME</u>		22d. LOCATION (City, town, or county) (State) <u>Jersey City, N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Guterman Funeral Home</u>		24a. REC'D BY REGISTRAR <u>4217-9th Ave</u> 24b. REGISTRAR'S SIGNATURE <u>Francis Pittery</u>	
DATE <u>DEC 26 1957</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Dec 20 1957</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

RECEIVED
DEC 26 1957
BUREAU V. 3

13347 CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Virginia c. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route #3, Box 514			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Deborah Middle Kathryn Last Holland				4. DATE OF DEATH Month December Day 3 Year 1957			
5. SEX Female		6. COLOR OR RACE Negroid		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 7, 1951	
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months 6 Days 3 Hours 3 Min.		IF UNDER 24 HRS. Months 6 Days 3 Hours 3 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minor Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME James Mercer				14. MOTHER'S MAIDEN NAME Ruby K. Holland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordiac arrest at operation 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital heart disease - Torus Arteriosus DUE TO (c) 6 yrs INTERVAL BETWEEN ONSET AND DEATH Immediate							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 24, 1957 , to December 3, 1957 , that I last saw the deceased alive on December 3, 1957 , and that death occurred at 12:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12-3-57 ACTUAL SIGNATURE Clarence S. Weldon M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Clarence S. Weldon, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		12-7-57		Shiloh Bapt.		Shiloh Corner Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Chini				ADDRESS Arlington Va.		24a. REC'D BY REGISTRAR DATE 12-11-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED James Henry</p>		<p>2. SEX Male</p>		<p>3. AGE 90 years</p>		<p>4. RACE White</p>	
<p>5. DATE OF DEATH December 2, 1957</p>		<p>6. PLACE OF DEATH The Clinical Center, Bethesda, Md.</p>		<p>7. PLACE OF BIRTH Baltimore, Md.</p>		<p>8. DATE OF BIRTH November 2, 1867</p>	
<p>9. NAME OF PHYSICIAN Dr. J. K. Holman</p>		<p>10. NAME OF HOSPITAL The Clinical Center, Bethesda, Md.</p>		<p>11. NAME OF NURSE Mary K. Holman</p>		<p>12. NAME OF ASSISTANT The Clinical Center, Bethesda, Md.</p>	
<p>13. CAUSE OF DEATH (To be filled in by physician)</p>		<p>14. MANNER OF DEATH (To be filled in by physician)</p>		<p>15. SIGNATURE OF PHYSICIAN J. K. Holman</p>		<p>16. SIGNATURE OF NURSE Mary K. Holman</p>	
<p>17. SIGNATURE OF ASSISTANT The Clinical Center, Bethesda, Md.</p>		<p>18. SIGNATURE OF DECEASED (If possible)</p>		<p>19. SIGNATURE OF WITNESSES (If possible)</p>		<p>20. SIGNATURE OF DECEASED (If possible)</p>	

BUREAU V. 5

DEC 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13348

CERTIFICATE OF DEATH

Reg. Dist. No.

13325
217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brinklow</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Co. Gen. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>WILLIAM</u> Last <u>HOLLAND</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 9, 1916</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HARRY HOLLAND</u>				14. MOTHER'S MAIDEN NAME <u>MABIE MATHEWS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W.W.#2</u>		16. SOCIAL SECURITY NO. <u>217-14-7188</u>		17. INFORMANT <u>Self.</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>587.0</u> DUE TO <u>Respiratory Collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Ileus</u> DUE TO <u>Acute Pancreatitis</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 days</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/15</u> , 1957, to <u>12/18</u> , 1957, that I last saw the deceased alive on <u>12/18</u> , 1957, and that death occurred at <u>5:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u> DATE SIGNED <u>12/18/57</u>							
ACTUAL SIGNATURE <u>C. H. LIGON</u>				PHYSICIAN'S NAME (Type) <u>C. H. LIGON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Quander</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 21 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Gertrude Lawley</u>	

MEDICAL CERTIFICATION

73

2

VS

BUREAU V. S.

DEC 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13349

CERTIFICATE OF DEATH

1332617

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md 4 yrs 8 mos</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Le Beau Gardens Sant.</u>				d. STREET ADDRESS <u>1213-33rd St NW</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>A.</u> Last <u>Houser</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 25, 1877</u>	
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MGR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>		11. BIRTHPLACE (State or foreign country) <u>POTOMAC, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEVI HOUSER</u>				14. MOTHER'S MAIDEN NAME <u>MARY COLLINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-01-9995</u>		17. INFORMANT <u>Francis Houser</u>		Address <u>Wash DC 1213-33rd St NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Dehydration</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Thrombosis</u> DUE TO lying cause lost. (c) <u>Chronic Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>February 19, 55</u> to <u>Dec. 1, 1957</u> , that I last saw the deceased alive on <u>Nov 30, 1957</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Robert J. Thibadeau</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Robert J. Thibadeau</u> <u>10609 Concord St., Kensington, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-4-57</u>		<u>POTOMAC CEMETERY</u>		<u>POTOMAC MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>				ADDRESS <u>3012-M St NW Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u>4</u> 24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DEC 4 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

13350

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>55 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>2105 Hanover</u>			
3. NAME OF DECEASED (Type or print) First <u>Sudie</u> Middle <u>BECKETT</u> Last <u>James</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 14/85</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Florence Warfield</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Silver Spring</u> <u>Hyattwood James, 2105 Hanover, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized peritonitis</u> DUE TO <u>578x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured ulcer, Ileum</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fibrocaceous granuloma, pulmonary, etiology indeterminate</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-8, 1955</u> to <u>Dec 15, 1957</u> , that I last saw the deceased alive on <u>Dec 15, 1957</u> , and that death occurred at <u>5:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Sharpe</u>				ADDRESS (Street, city or town, state) <u>10511 Summit Ave Kensington, Md</u>			
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>				DATE SIGNED <u>12/15/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				ADDRESS <u>Mt Rainier</u>		24a. REC'D BY REGISTRAR <u>DATE 20 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Russie Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 20 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13328

Reg. Dist. No. 217

13351

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood R - 1	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X / Derwood R - 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Muncaster Mill Rd.		d. STREET ADDRESS Muncaster Mill Rd.	
3. NAME OF DECEASED (Type or print) Earl Jarrett		4. DATE OF DEATH Dec. 14, 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/1903
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (State or foreign country) N. C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Arthur W. Jarrett	
14. MOTHER'S MAIDEN NAME Vannie Jattis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. 5781427982		17. INFORMANT Police record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Found dead in bed.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/15/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 17, 57	22c. NAME OF CEMETERY OR CREMATORY Laytonsville Meth.	22d. LOCATION (City, town, or county) (State) Laytonsville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		24a. REC'D BY REGISTRAR 12-19-57	
ADDRESS Laytonsville, Md.		24b. REGISTRAR'S SIGNATURE Bertine B. Lawler	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE HEALTH DEPT.

1935

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

317

UNKNOWN

BUREAU V. S.

DEC 23 1937

RECEIVED

Laytonville, Md.

Laytonville, Md.

Dec. 17, 37

Butler

Laytonville, Md. 11-17-37

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13271

CERTIFICATE OF DEATH

133243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keyser	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 81 Willow Ave.	
3. NAME OF DECEASED (Type or print) William Otis Jennings		4. DATE OF DEATH Month Dec. Day 22 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/16
9. AGE (In years last birthday) yrs. 43		IF UNDER 1 YEAR Months 22 Days 15 Hours 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? West Virginia	
13. FATHER'S NAME Otis Vernon Jennings		14. MOTHER'S MAIDEN NAME Nora Belle Dressler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 491X	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia DUE TO (c) Chronic Glomerulonephritis		INTERVAL BETWEEN ONSET AND DEATH One day Three months One year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 12, 1957 , to Dec 22, 1957 , that I last saw the deceased alive on Dec 22, 1957 , and that death occurred at 5:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Morton Eanet		ADDRESS (Street, city or town, state) 900 12th St. N.W. Wash.	
PHYSICIAN'S NAME (Type) MORTON EANET M.D.		DATE SIGNED J.C. 12/23/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 12/23/57	22c. NAME OF CEMETERY OR CREMATORY Keyser, West Virginia	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 26 1957	
24b. REGISTRAR'S SIGNATURE Wilson		24c. ADDRESS 14th St. N.W. Washington, D.C.	

BUREAU A

DEC 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

DEC 19 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13353 CERTIFICATE OF DEATH

13331 214

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>13613 SHERWOOD FOREST DR</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ASTRID SOPHIE JOHNSON</u>				4. DATE OF DEATH Month Day Year <u>DEC. 15 19 57</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 28, 1881</u> 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MICH.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>JOHN D. JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>T. ROBERT JOHNSON - 6715 RELEE RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January, 1950</u> to <u>Dec. 15, 1957</u> , that I last saw the deceased alive on <u>Dec. 15, 1957</u> , and that death occurred at <u>8:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Robert Perkins</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>1463 - Rhode Island Ave NW 12/15/57</u>			
PHYSICIAN'S NAME (Type) <u>William Robert Perkins M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/18/57</u>		<u>Prospect Hill</u>		<u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. W. Lees Son - Wash. D. C.</u>				24a. REC'D BY REGISTRAR <u>DEC 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Pattery</u>	

CERTIFICATE OF DEATH

1932

NAME OF DECEASED <i>John B. Johnson</i>		SEX <i>Male</i>		AGE <i>45</i>	
DATE OF DEATH <i>Dec 18 1932</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>None</i>	
SIGNATURE OF PHYSICIAN <i>John B. Johnson</i>		SIGNATURE OF WITNESS <i>John B. Johnson</i>		SIGNATURE OF DECEASED <i>John B. Johnson</i>	
DATE OF SIGNATURE <i>Dec 18 1932</i>		DATE OF SIGNATURE <i>Dec 18 1932</i>		DATE OF SIGNATURE <i>Dec 18 1932</i>	

BUREAU V. S.

DEC 18 1932

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13272

CERTIFICATE OF DEATH

133323
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Riverdale</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saboma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
c. LENGTH OF STAY IN 1b <u>25 days</u>		1625.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp.</u>		d. STREET ADDRESS <u>5906 Sheridan St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harold Plant Johnson</u>		4. DATE OF DEATH Month Day Year <u>12-24 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-8-99</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Con mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John C. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Settle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unknown) <u>no</u> (If yes, give year or kind of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>578-034274</u>	
17. INFORMANT <u>Chart</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemo peritoneum</u> <u>451X</u> DUE TO <u>Rupture arteriosclerotic aortic aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusions</u> (c) <u>Coronary Occlusions</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>? hours</u> <u>2 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>10-1-</u> , 19 <u>57</u> , to <u>12-24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-24</u> , 19 <u>57</u> , and that death occurred at <u>9:15 P.</u> M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Robert A. Hare</u>	ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>
DATE SIGNED <u>12/25/57</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. HARE</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/28/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WASH. NAT. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>NW Chambers Co.</u>		24. REGISTRAR'S SIGNATURE <u>John H. Hadd</u>	
ADDRESS <u>5801 Cleveland Ave</u>		DATE <u>12 6 1957</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		M		65		JAN 15 1868		BALTIMORE		BALTIMORE		BALTIMORE		MD	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		CITY		COUNTY		STATE	
RETIRED		HEART DISEASE		NATURAL		2 WEEKS		BALTIMORE		BALTIMORE		BALTIMORE		MD	
DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		WEIGHT		HEIGHT	
JAN 20 1933		10:30 AM		100.0		80		20		120/80		170		5' 8"	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		WEIGHT		HEIGHT	
JAN 20 1933		10:30 AM		100.0		80		20		120/80		170		5' 8"	

BUREAU V. S.

JAN 6 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

13333

13292

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>	
TOWN <u>1 yr.</u>		TOWN <u>26 XXXXX</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15209 Rosecroft Rd.</u>		STREET ADDRESS <u>15209 ROSE CROFT ROAD</u>	
3. NAME OF DECEASED (First, Middle, Last) <u>GEORGE KARL JUDICKE</u>		4. DATE OF DEATH (Month, Day, Year) <u>Dec. 5 1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug 22/1931</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Production Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	9. AGE last birthday <u>64</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Rheinhold Judicke</u>		14. MOTHER'S MAIDEN NAME <u>Anna Kramer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY No. <u>136-14-3259</u>	
17. INFORMANT <u>Widow</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>163X Carcinoma of lung</u>		<u>9 mo.</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>auricular fibrillation - right bundle branch block</u>		<u>9 mo</u>	
19a. DATE OF OPERATION <u>March 23/1957</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of lung - inoperable</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 15, 1957</u> , to <u>Dec 5, 1957</u> , that I last saw the deceased alive on <u>Nov 23, 1957</u> , and that death occurred at <u>6 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Lester W Harris M.D.</u>		DATE SIGNED <u>12-5-57</u>	
23. BURIAL, CREMATION OR OTHER REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>12/9/57</u>	
NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
DATE REC'D BY LOCAL REG. <u>12-17-57</u>		24. FUNERAL DIRECTOR <u>Francis Peter</u> ADDRESS <u>SILVER SPRING, MD.</u>	

Two for One: FilmG223 12-30-57 et

BUREAU V. S.

DEC 23 1957

RECEIVED

13354 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 43 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 5708 Danny's Lane			
3. NAME OF DECEASED (Type or print) First Wilhelmina Middle Suarez Last KETTERER				4. DATE OF DEATH Month December Day 23 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 July 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George Raldolph SUAREZ				14. MOTHER'S MAIDEN NAME Mary Mildred JOHNSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Son) Frederick KETTERER (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 434.1 Pulmonary Embolism, Left upper lobe IMMEDIATE CAUSE (a) 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Conjunctive Heart Failure DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8 November , 19 57 , to 23 December , 19 57 , that I last saw the deceased alive on 23 December , 19 57 , and that death occurred at 8:37A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-23-57							
ACTUAL SIGNATURE John Craighead				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) John Craighead, LCDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-27-57		22c. NAME OF CEMETERY OR CREMATORY Barrancas Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Pensacola, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home				ADDRESS 2847 Wilson Blvd. Arlington, Va.		24a. REC'D BY REGISTRAR DATE 12-23-57	
24b. REGISTRAR'S SIGNATURE Mary E. Parrelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. ROYAL		AGE 45		SEX Male		RACE White	
DATE OF DEATH Dec 28 1957		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
OCCUPATION Salesman		EDUCATION High School		MARRIAGE Married		RELIGION Roman Catholic	
BIRTH Dec 15 1912		PLACE OF BIRTH Baltimore		FATHER'S NAME John J. Royal		MOTHER'S NAME Mary Ann Royal	
PREVIOUS ILLNESS None		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF NEXT OF KIN [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF REGISTRAR [Signature]	

BUREAU A. T.

DEC 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

133355

133355
Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 00 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) OLLIE'S SNACK BAR		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PAW PAW c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW d. STREET ADDRESS ROUTE #1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GILBERT CLARENCE KIDWELL		4. DATE OF DEATH Month DECEMBER Day 5 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 19, 1897
9. AGE (in years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator of cranes & tractors		10b. KIND OF BUSINESS OR INDUSTRY Ray Construction Co	
11. BIRTHPLACE (State or foreign country) Paw Paw, West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Kidwell		14. MOTHER'S MAIDEN NAME Gordelia Kidwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 236-50-1573	
17. INFORMANT Mrs. Olive Kidwell		Address 3601 Weller Rd. S. S. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 420.1 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/5/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 8, 1957	
22c. NAME OF CEMETERY OR CREMATORY Camp Hill Cemetery		22d. LOCATION (City, town, or county) (State) Paw Paw, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS 8434 Georgia Ave. Silver Spring, Md.	
24a. REC'D BY REGISTRAR DEC 9 1957		24b. REGISTRAR'S SIGNATURE Francis Patter	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Birth: [illegible]
5. Place of Birth: [illegible]
6. Usual Residence: [illegible]
7. Cause of Death: [illegible]
8. Manner of Death: [illegible]
9. Signature of Examiner: [illegible]
10. Date of Examination: [illegible]

BUREAU V. S.

DEC 9 1957

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13356

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 51 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, BETHESDA, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, D.C. b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 3409 O St., N.W., WDC e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last TRACY BARRETT KITTREDGE				4. DATE OF DEATH Month Day Year December 22 19 57			
5. SEX MALE		6. COLOR OR RACE CAUC.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 May 1891	
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. NAVAL RESERVE		10b. KIND OF BUSINESS OR INDUSTRY USN		11. BIRTHPLACE (State or foreign country) OREGON	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME HERBERT KITTREDGE		14. MOTHER'S MAIDEN NAME JESSE GROOVES		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI, WWII	
16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT OFFICIAL NAVY RECORDS		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodkins Disease 201x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1 November 1957 , to 22 December 1957 , that I last saw the deceased alive on 22 December 1957 , and that death occurred at 7:14 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) USNH, BETHESDA, MARYLAND DATE SIGNED 12-22-57							
ACTUAL SIGNATURE August Miale Jr. M.D. USNH, BETHESDA, MARYLAND		PHYSICIAN'S NAME (Type) A. MIALE Jr. USNH, BETHESDA, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-22-57		22c. NAME OF CEMETERY OR CREMATORY ANCIENT CEMETERY		22d. LOCATION (City, town, or county) (State) WISCASSETT MAINE	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY ADDRESS 757 Wisconsin Ave., Bethesda, MD		24a. REC'D BY REGISTRAR DATE 12-22-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

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DEC 26 1957
BUREAU V. S.

Handwritten signature or initials at the bottom right of the form.

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Chevy Chase c. LENGTH OF STAY IN 1b 52 Bethesda Chevy Chase d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3520 Bradley Lane		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Chevy Chase d. STREET ADDRESS 3520 Bradley Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NORA First C. Middle KNAPP Last		4. DATE OF DEATH Dec. 19 Month 19 Day 57 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/27/70
9. AGE (In years and birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 5 Days 29	11. IF UNDER 24 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mathew V. Callaway		14. MOTHER'S MAIDEN NAME Alice Callahan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Montg. Co. Police		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 hrs INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/20/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/23/57	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company		24a. REC'D BY REGISTRAR 23 1957 24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEC 23 1957

BUREAU V. S.

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STATE AND STATE DEPARTMENT OF HEALTH-BALTIMORE, 19

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

19 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13338	
Items 18&21 Film 224 1-6-58 ams										214	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					c. LENGTH OF STAY IN 1b 56					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MANCHESTER 9051 Manchester Rd.					1. STREET ADDRESS 9051 MANCHESTER ROAD					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Augustus Washington Knox, Jr.					4. DATE OF DEATH Dec. 23, 1957					Year 19	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/7/1903		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor					10b. KIND OF BUSINESS OR INDUSTRY Tel. Co.		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Augustus Washington Knox Sr.					14. MOTHER'S MAIDEN NAME Eliza Smides						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]					16. SOCIAL SECURITY NO. 061-10-4193		17. INFORMANT Address Eliza Smides Knox Sameas Item 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Barbiturate poisoning 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH Found dead in bed	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschart M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					12/23/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)			
TRANS & BURIAL			12/24/57		Oakwood Cemetery			Raleigh, North Carolina			
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey					ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE James Pattery		

DEC 26 1957

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DEC 26 1957

BUREAU V. 3

1336

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]

2. SEX: [illegible]

3. AGE: [illegible]

4. DATE OF BIRTH: [illegible]

5. PLACE OF BIRTH: [illegible]

6. OCCUPATION: [illegible]

7. CAUSE OF DEATH: [illegible]

8. MANNER OF DEATH: [illegible]

9. SIGNATURE OF EXAMINER: [illegible]

10. DATE OF EXAMINATION: [illegible]

11. TIME OF EXAMINATION: [illegible]

12. PLACE OF EXAMINATION: [illegible]

13. SIGNATURE OF WITNESS: [illegible]

14. DATE OF SIGNATURE: [illegible]

15. TIME OF SIGNATURE: [illegible]

16. PLACE OF SIGNATURE: [illegible]

17. SIGNATURE OF SECOND WITNESS: [illegible]

18. DATE OF SIGNATURE: [illegible]

19. TIME OF SIGNATURE: [illegible]

20. PLACE OF SIGNATURE: [illegible]

21. SIGNATURE OF THIRD WITNESS: [illegible]

22. DATE OF SIGNATURE: [illegible]

23. TIME OF SIGNATURE: [illegible]

24. PLACE OF SIGNATURE: [illegible]

25. SIGNATURE OF FOURTH WITNESS: [illegible]

26. DATE OF SIGNATURE: [illegible]

27. TIME OF SIGNATURE: [illegible]

28. PLACE OF SIGNATURE: [illegible]

29. SIGNATURE OF FIFTH WITNESS: [illegible]

30. DATE OF SIGNATURE: [illegible]

31. TIME OF SIGNATURE: [illegible]

32. PLACE OF SIGNATURE: [illegible]

33. SIGNATURE OF SIXTH WITNESS: [illegible]

34. DATE OF SIGNATURE: [illegible]

35. TIME OF SIGNATURE: [illegible]

36. PLACE OF SIGNATURE: [illegible]

37. SIGNATURE OF SEVENTH WITNESS: [illegible]

38. DATE OF SIGNATURE: [illegible]

39. TIME OF SIGNATURE: [illegible]

40. PLACE OF SIGNATURE: [illegible]

41. SIGNATURE OF EIGHTH WITNESS: [illegible]

42. DATE OF SIGNATURE: [illegible]

43. TIME OF SIGNATURE: [illegible]

44. PLACE OF SIGNATURE: [illegible]

45. SIGNATURE OF NINTH WITNESS: [illegible]

46. DATE OF SIGNATURE: [illegible]

47. TIME OF SIGNATURE: [illegible]

48. PLACE OF SIGNATURE: [illegible]

49. SIGNATURE OF TENTH WITNESS: [illegible]

50. DATE OF SIGNATURE: [illegible]

51. TIME OF SIGNATURE: [illegible]

52. PLACE OF SIGNATURE: [illegible]

53. SIGNATURE OF ELEVENTH WITNESS: [illegible]

54. DATE OF SIGNATURE: [illegible]

55. TIME OF SIGNATURE: [illegible]

56. PLACE OF SIGNATURE: [illegible]

57. SIGNATURE OF TWELFTH WITNESS: [illegible]

58. DATE OF SIGNATURE: [illegible]

59. TIME OF SIGNATURE: [illegible]

60. PLACE OF SIGNATURE: [illegible]

61. SIGNATURE OF THIRTEENTH WITNESS: [illegible]

62. DATE OF SIGNATURE: [illegible]

63. TIME OF SIGNATURE: [illegible]

64. PLACE OF SIGNATURE: [illegible]

65. SIGNATURE OF FOURTEENTH WITNESS: [illegible]

66. DATE OF SIGNATURE: [illegible]

67. TIME OF SIGNATURE: [illegible]

68. PLACE OF SIGNATURE: [illegible]

69. SIGNATURE OF FIFTEENTH WITNESS: [illegible]

70. DATE OF SIGNATURE: [illegible]

71. TIME OF SIGNATURE: [illegible]

72. PLACE OF SIGNATURE: [illegible]

73. SIGNATURE OF SIXTEENTH WITNESS: [illegible]

74. DATE OF SIGNATURE: [illegible]

75. TIME OF SIGNATURE: [illegible]

76. PLACE OF SIGNATURE: [illegible]

77. SIGNATURE OF SEVENTEENTH WITNESS: [illegible]

78. DATE OF SIGNATURE: [illegible]

79. TIME OF SIGNATURE: [illegible]

80. PLACE OF SIGNATURE: [illegible]

81. SIGNATURE OF EIGHTEENTH WITNESS: [illegible]

82. DATE OF SIGNATURE: [illegible]

83. TIME OF SIGNATURE: [illegible]

84. PLACE OF SIGNATURE: [illegible]

85. SIGNATURE OF NINETEENTH WITNESS: [illegible]

86. DATE OF SIGNATURE: [illegible]

87. TIME OF SIGNATURE: [illegible]

88. PLACE OF SIGNATURE: [illegible]

89. SIGNATURE OF TWENTIETH WITNESS: [illegible]

90. DATE OF SIGNATURE: [illegible]

91. TIME OF SIGNATURE: [illegible]

92. PLACE OF SIGNATURE: [illegible]

93. SIGNATURE OF TWENTY-FIRST WITNESS: [illegible]

94. DATE OF SIGNATURE: [illegible]

95. TIME OF SIGNATURE: [illegible]

96. PLACE OF SIGNATURE: [illegible]

97. SIGNATURE OF TWENTY-SECOND WITNESS: [illegible]

98. DATE OF SIGNATURE: [illegible]

99. TIME OF SIGNATURE: [illegible]

100. PLACE OF SIGNATURE: [illegible]

13273 CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park, M</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hospital</u>				d. STREET ADDRESS <u>3806 Flower Ave.,</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Infant Girl</u> First Middle Last				4. DATE OF DEATH <u>December 14, 1957</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 12, 1957</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u>		IF UNDER 24 HRS. Days <u>2</u> Hours <u>44</u> Min. <u>44</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph Stanley Leacy</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Ann Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother's chart</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory + Cardiac Failure.</u> 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity.</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12 Dec.</u> , 19 <u>57</u> , to <u>14 Dec.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>14 Dec.</u> , 19 <u>57</u> , and that death occurred at <u>10:35a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Bier</u>				ADDRESS (Street, city or town, state) <u>9028 Woodland Drive Silver Spring Maryland.</u>			
DATE SIGNED <u>12/16/57</u>							
PHYSICIAN'S NAME (Type) <u>Robert A. BIER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park, 12, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Bier</u> ADDRESS <u>Washington San. & Hospital</u>				24a. REC'D BY REGISTRAR <u>DEC 21 1957</u> 24b. REGISTRAR'S SIGNATURE <u>J. H. Wilson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2175261XVI

RECEIVED

13274

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 17			
c. LENGTH OF STAY IN 1b <u>19 hours 39 min</u>				d. STREET ADDRESS <u>3806 Flower Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Infant Boy Leacy</u>				4. DATE OF DEATH <u>December 13 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 12, 1957</u>	
9. AGE (In years last birthday) yrs. <u>19</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ralph Stanley Leacy</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Ann Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mother's chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory & Cardiac Failure</u> 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 12, 1957</u> to <u>Dec. 13, 1957</u> , that I last saw the deceased alive on <u>Dec. 13, 1957</u> , and that death occurred at <u>2:15 p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Bier</u>		M.D. <u>9028 Woodland Dr. 16 Dec 57</u>		ADDRESS (Street, city or town, state) <u>Silver Spring Md.</u>		DATE SIGNED.	
PHYSICIAN'S NAME (Type) <u>Robert A. BIER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Bier, M.D.</u>				24a. REC'D BY REGISTRAR <u>DEC 21 1957</u>			
ADDRESS <u>Washington San. & Hosp.</u>				24b. REGISTRAR'S SIGNATURE <u>William Dodd</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2275262XV2

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		JAN 15 1900		NEW YORK	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 15 1920		NEW YORK		JANE J. JONES		JAN 15 1950		NEW YORK	
CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		CORONARY ARTERY DISEASE		ANGINA PECTORIS		HYPERTENSION		JAN 15 1950		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		NAME OF NURSE		NAME OF MINISTER		NAME OF CHURCH	
JAN 15 1950		NEW YORK		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF NURSE		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	

BUREAU V. 8

DEC 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13275

CERTIFICATE OF DEATH

Reg. Dist. No. **13341**

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. + Hosp.</u>				d. STREET ADDRESS <u>1302 Longfellow St. N.W.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Logeman</u> Last <u>Logeman</u>				4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/8/79</u>		9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>14</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Logeman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-09-6728A</u>		17. INFORMANT <u>Adolph</u> Address <u>Wiece Mrs Mary Ziese 7121 8th St N.W. D.C.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>5 yrs</u>								INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>12</u> Day <u>17</u> Year <u>1957</u> Hour <u>11</u> a. m. <u>57</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>57</u> , to <u>Dec 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 14</u> , 19 <u>57</u> , and that death occurred at <u>1:35 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>401 Kennedy St NW</u> DATE SIGNED <u>Wash D.C.</u>									
ACTUAL SIGNATURE <u>M. F. OTTMAN</u> M.D.				PHYSICIAN'S NAME (Type) <u>M. F. OTTMAN</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>2901 14th St. N.W.</u> <u>The S.H. Hines Co. Washington 9, D.C.</u>						24a. REC'D BY REGISTRAR DATE <u>DEC 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 101-114

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13276 CERTIFICATE OF DEATH

1334273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7216 Holly Ave.</u>				e. STREET ADDRESS <u>7216 Holly Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Caroline A. Longfellow</u>				4. DATE OF DEATH Month Day Year <u>Dec. 15, 1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/11/63</u>	9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Longfellow & Rhodes Publishers Iowa</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>David Longfellow</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Bessie H. Guerrey</u>		Address <u>7216 Holly Ave. Takoma Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Arterio Sclerosis (General)</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 yrs?</u> <u>15 yrs?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X6 calculi</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>15</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1930</u> , 19 <u>57</u> , to <u>12/15/57</u> , that I last saw the deceased alive on <u>12/15/57</u> , 19 <u>57</u> , and that death occurred at <u>7:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. B. Sims</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1150 Connecticut Ave. N.W.</u>			
PHYSICIAN'S NAME (Type) <u>W. B. Sims</u>				<u>1150 Conn. Ave.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>12/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>12/19/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Dadd</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. P.

DEC 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13343

Reg. Dist. No. 2, 46

13359

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown, Md.</u>	
		d. STREET ADDRESS <u>R. 7. D. # 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Eugene</u> Last <u>Lowe, Jr.</u>		4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1925</u>
9. AGE (In years last birthday) <u>32 yrs.</u>		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Germanstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard E. Lowe, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Nellie E. Arp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Lawrence D. Lowe, Germanstown, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Infarction</u> <u>812X</u> DUE TO <u>Basal Skull Fracture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 days</u> DUE TO <u>Automobile accident</u> (c) <u>2 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral fractures of tibia and fibula</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Pedestrian - Struck by auto</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>U.S. Route 355 - Declared monty md</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:00</u> a.m. <u>12-26</u> 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U.S. Route 355</u>		20f. (City or town) <u>Declared monty md</u> (County) <u> </u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>12-29-57</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-31-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

IDENTIFICATION
Name of Deceased: *Richard E. Lawrence*
Age: *21*
Sex: *M*
Date of Birth: *Jan 3, 1938*
Place of Birth: *German town, Ill.*
Residence: *1221 1/2 St. N. W.*
Occupation: *Farmer*
Cause of Death: *Accident*
Place of Death: *German town, Ill.*
Date of Death: *Jan 3, 1938*
Time of Death: *11:21*
Signature of Medical Examiner: *[Signature]*
Signature of Coroner: *[Signature]*

RECEIVED
JAN 3 1938
BUREAU V. B.

13360 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 16 days				d. STREET ADDRESS 3725 Fessenden Street, N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle (nmn) Last LOWERY				4. DATE OF DEATH Month December Day 24 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 August 1856	
9. AGE (In years, lost birthday) 101 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - -		11. BIRTHPLACE (State or foreign country) Connecticut	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Thomas J. Shaunnassy				14. MOTHER'S MAIDEN NAME Elizabeth Shepherd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Daughter) Mrs. Sara S. Harrison (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 December , 19 57 , to 24 December , 19 57 , that I last saw the deceased alive on 24 December , 19 57 , and that death occurred at 7:22A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, NNMC, Bethesda, Md. DATE SIGNED 12-24-57							
ACTUAL SIGNATURE John T. Craighead M.D. U.S. Naval Hospital, NNMC, Bethesda, Md.							
PHYSICIAN'S NAME (Type) John T. Craighead, LCDR, MC, USN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-28-57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Chevy Chase Funeral Home, 5103 Wisconsin Ave.,				24. REC'D BY REGISTRAR 12-24-57			
24b. REGISTRAR'S SIGNATURE May E. Parrelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. A.

DEC 30 1957

RECEIVED

•13277 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PP.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>	
c. LENGTH OF STAY IN lb <u>2 days</u>		d. STREET ADDRESS <u>11507 Montgomery Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hazel Bernice Lubbes</u>		4. DATE OF DEATH Month Day Year <u>Dec. 28 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-15</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Henry Young</u>		14. MOTHER'S MAIDEN NAME <u>Grace Ridd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or periods of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>	
17. INFORMANT <u>Charles</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute viral hepatitis</u> <u>580X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Distinction between toxic and</u> DUE TO (c) <u>serum hepatitis pending</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral edema</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 20</u> , 19 <u>57</u> , to <u>Dec. 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 28</u> , 19 <u>57</u> , and that death occurred at <u>10:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.W. Smith</u>		DATE SIGNED <u>12/29/57</u>	
PHYSICIAN'S NAME (Type) <u>A.W. SMITH</u>		ADDRESS (Street, city or town, state) <u>13018 GEORGIA AVE. SILVER SPRING, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/31/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St., N.W.</u>		24a. REC'D BY REGISTRAR <u>DEC 31 1957</u>	
ADDRESS <u>Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Wilson</u>	

DEC 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13346

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Anne Arundel ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 910 Ridgewood Street			
3. NAME OF DECEASED (Type or print) First Robert Middle Allen Last Maddocks				4. DATE OF DEATH Month December Day 27 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1924	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY Naval Academy	
11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Earlston L. Maddocks		14. MOTHER'S MAIDEN NAME Luella Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT MELANOMA with widespread metastases DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from December 9, 19 57 , to December 27, 19 57 , that I last saw the deceased alive on December 27, 19 57 , and that death occurred at 2:45p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward A. Moore M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/28/57			
PHYSICIAN'S NAME (Type) EDWARD A. MOORE, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cent		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Hupf				ADDRESS Annapolis		24a. REC'D BY REGISTRAR DATE 12/31/57	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1958 JAN 26

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13362

CERTIFICATE OF DEATH

Reg. Dist. No.

1334214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RDI Silver Spring, Bradley Rest</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BRADFORD REST Home</u>		d. STREET ADDRESS <u>Poolesville</u>	
3. NAME OF DECEASED (Type or print) <u>Charlotte</u> First <u>Martin</u> Middle <u>1</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-1869</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>38</u> Days <u>38</u> Hours <u>38</u> Min. <u>38</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos GENIES</u>		14. MOTHER'S MAIDEN NAME <u>Mary ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Nursing Record</u>		Address <u>RDI Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Cecum</u> <u>153x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inanition, anemia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-19</u> , 19 <u>57</u> , to <u>12-31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-19</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clare E. Jackson</u> M.D.		DATE SIGNED <u>12-31-57</u>	
PHYSICIAN'S NAME (Type) <u>RDI, Catheburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jerusalem Baptist.</u>	22d. LOCATION (City, town, or county) (State) <u>Poolesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 7 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	

BUREAU V. S.

JAN 7 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13363

Items 1c, 11 Film 22, 1-20-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

13348

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 Yrs. 4 Mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md. x 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resistor San.</u>				d. STREET ADDRESS <u>4823 Rugby Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>McClure</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.H.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>24 March 1882</u>	
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>19</u> Min. <u>57</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>Wm. John McClure</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mae Gessford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Rogers McClure (SON)</u> Address <u>4823 Rugby Ave. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> <u>502.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bronchiectasis</u> (c) <u>chronic emphysema</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 years</u> <u>15 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic heart disease with cong. aortic valve</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>57</u> , and that death occurred at <u>6:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D.				ADDRESS (Street, city or town, state) <u>4890 Battery Lane, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut M.D.</u>				DATE SIGNED <u>Dec 22</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12-24-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bruce M. Thompson</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

DEC 27 1937

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13364 CERTIFICATE OF DEATH

13349

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Suburban-Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>15346 Poole Hill Ct</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>McCULLOUGH, Thomas Edward</u>				4. DATE OF DEATH <u>DEC 29 1957</u>			
5. SEX <u>BoY</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 28, 1957</u>	
9. AGE (In years last birthday) <u>Newborn</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u>14</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Harry J. McCullough</u>				14. MOTHER'S MAIDEN NAME <u>Ann Copp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harry J. McCullough</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>38 HRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC 28, 1957</u> to <u>DEC 29, 1957</u> , that I last saw the deceased alive on <u>DEC 29, 1957</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>4700 BRADLEY BLVD</u>				DATE SIGNED			
ACTUAL SIGNATURE <u>IRA W. PEARLMAN</u> M.D.							
PHYSICIAN'S NAME (Type) <u>DR. IRA W. PEARLMAN</u>				<u>CHERYL CHASE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/2/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>7557 Wis. Ave. Bethesda, Md</u>		24a. REC'D BY REGISTRAR <u>DATE 12-31-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

2074 376 XVO

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Birth Date

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. 3

JAN 3 1938

RECEIVED

Baltimore

Baltimore National

1/3/1938

1/3/1938

Robert L. Humphrey-Johnson, M.D.

13365

CERTIFICATE OF DEATH

13350

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 47 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NMMC, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE North Carolina b. COUNTY Wilson c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 70x-3 d. STREET ADDRESS Route #4 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Willie James MEADOWS				4. DATE OF DEATH Month Day Year December 26 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 September 1896	
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer and Grocer		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Luther MEADOWS				14. MOTHER'S MAIDEN NAME Daisy GRIMSLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 3-5-18 to 3-1-19				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Daughter Sarah A MEADOWS 3200 16th St. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 <i>Acute myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary atherosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death 1 hour Several years						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 November 1957 to 26 December 1957 , that I last saw the deceased alive on 26 December 1957 , and that death occurred at 1:33 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, NMMC, Bethesda Md. 12-27-57							
ACTUAL SIGNATURE Robert P. Dobbie, Jr. CDR, MC, USN				M.D. U.S. Naval Hospital, NMMC, Bethesda Md. 12-27-57			
PHYSICIAN'S NAME (Type) Robert P. Dobbie, Jr. CDR, MC, USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-57		22c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		22d. LOCATION (City, town, or county) (State) Wilson, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Hunts Funeral Home				ADDRESS 115 N. Tarboro St. Wilson, N.C.		24a. REC'D BY REGISTRAR ONE 12-27-57	
				24b. REGISTRAR'S SIGNATURE Mary E. Savelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

DEC 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13366

CERTIFICATE OF DEATH

13351

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b 6 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7411 Wyndale Lane				d. STREET ADDRESS 7411 Wyndale Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ella Middle Rourke Last Mee				4. DATE OF DEATH Month Dec. Day 28 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1866		9. AGE (In years last birthday) 91 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sterling, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Rourke				14. MOTHER'S MAIDEN NAME Mary Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. C.F. Mueller Address 7411 Wyndale La., Chevy Chase, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general and cerebral DUE TO 10 years (c) _____				INTERVAL BETWEEN ONSET AND DEATH 3 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) _____	
21. I certify that I attended the deceased from Nov 30, 1951 to Dec 28, 1957 , that I last saw the deceased alive on Dec 28, 1957 , and that death occurred at 7:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1150 Connecticut Ave., N.W., Wash. 6, D.C. DATE MOVED Dec 28, 1957							
ACTUAL SIGNATURE Frank S. Bacon M.D.				PHYSICIAN'S NAME (Type) Frank S. Bacon			
22a. BURIAL, CREMATION, or other disposition Burial		22b. DATE THEREOF 12/31/57		22c. NAME OF CEMETERY OR CREMATORY Calvary		22d. LOCATION (City, town, or county) (State) Sterling, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 12-31-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. 2

JAN 3 1938

RECEIVED

RECEIVED
JAN 3 1938
BUREAU V. 2

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Germananton</i>		c. LENGTH OF STAY IN 1b <i># 73 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>at home</i>		d. STREET ADDRESS <i>—</i>	
3. NAME OF DECEASED (Type or print) <i>William Frederick Metz</i> First Middle Last		4. DATE OF DEATH <i>Dec-21-1967</i> Month Day Year	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec-23-1882</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months <i>11</i> Days <i>25</i>	IF UNDER 24 HRS. Hours <i>—</i> Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farming, carpentry</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farm, home</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Enock Metz</i>		14. MOTHER'S MAIDEN NAME <i>Francis Rebecca Snyder</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-07-3726</i>	
17. INFORMANT <i>Mary M. Horton, Germananton, Md.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute heart failure</i> 443x DUE TO <i>Chronic myocardial insufficiency</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <i>High arterial tension, periodically</i>			INTERVAL BETWEEN ONSET AND DEATH <i>23-30 minutes</i> <i>3 years</i> <i>5 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March</i> , 19 <i>52</i> , to <i>Dec-21-</i> , 19 <i>67</i> , that I last saw the deceased alive on <i>Dec-19-</i> , 19 <i>67</i> , and that death occurred at <i>1 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William C. Miller</i>		ADDRESS (Street, city or town, state) <i>7-Brooks Ave., Gaithersburg, Md.</i>	
PHYSICIAN'S NAME (Type) <i>William C. Miller</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-23-67</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Bethel Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Germananton Md-</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest C. Garton Gaithersburg, Md.</i> ADDRESS		24a. REC'D BY REGISTRAR <i>—</i> DATE <i>Dec-23-67</i>	24b. REGISTRAR'S SIGNATURE <i>Abner G. Crook</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

at home
Funeral home
Interment

2-19-1907

Funeral home
Interment

William C. Miller

male white

44-22-1882

George C. Miller
Funeral home
Interment

2-19-1907
Funeral home
Interment

George C. Miller
Funeral home
Interment

BUREAU V. S.

DEC 30 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13368

Items 8, 9 Film 0223 12-27-57 et

Reg. Dist. No. 214

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN TB <u>14 yrs</u>		d. STREET ADDRESS <u>9921 Rogart Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9921 Rogart Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Preston Ellsworth Miller</u>		4. DATE OF DEATH <u>Dec 20</u> 19 <u>57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR: Months <u>4</u> Days <u>17</u> Hours <u>41</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner of -- golf driving Range</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas E Miller</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Glosbach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Police Bureau</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>shot gun wound thru left chest</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted shot gun wound</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/24/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. MEM. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DEC 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 23 1957

BUREAU V. 2

CERTIFICATE OF DEATH

Reg. Dist. No.

13354
214

13369

1. PLACE OF DEATH a. COUNTY <i>Montg</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>MONTG.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. STREET ADDRESS <i>512 Mansfield Rd.</i>			
3. NAME OF DECEASED (Type or print) First <i>LOUIS</i> Middle <i>MOGIN</i> Last <i>MOGIN</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>2</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UPHOLSTERER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-48-3176</i>	
17. INFORMANT <i>LESTER E MOGIN - 512 MANSFIELD RD. SPR.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO <i>or Hypertension</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>ca 6 hours</i> <i>37 years</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>January 15, 1942</i> , to <i>Nov. 23, 1957</i> , that I last saw the deceased alive on <i>Nov. 23, 1957</i> , and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>204 One St. N.W.</i> DATE SIGNED			
ACTUAL SIGNATURE <i>Hypnotism</i>		M.D. <i>204 One St. N.W.</i>	
PHYSICIAN'S NAME (Type) <i>HUGO EINSTEIN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>12/3/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>GEO. WASH. CEM. INC</i>	22d. LOCATION (City, town, or county) (State) <i>Hyattsville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home Wash. D.C.</i>		24a. REC'D BY REGISTRAR <i>12/6/57</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

13278

CERTIFICATE OF DEATH

Reg. Dist. No.

13355 3

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL				d. STREET ADDRESS 56 SILVER SPRING 8704 Colesville Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ARTHUR Middle PAUL Last MOON				4. DATE OF DEATH Month DEC. Day 10 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 28, 1894	
9. AGE (In years last birthday) 63		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Mgr. - Printing Company				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Arthur Paul Moon				14. MOTHER'S MAIDEN NAME Mary Labery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 207-07-4896			
17. INFORMANT Miss Joan M. Moon, 8704 Colesville Road				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 148X Terminal Cancer DUE TO Terminal Cachexia DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 mos 1 wk			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 7, 1945 , to Dec 10, 1957 , that I last saw the deceased alive on Dec 10, 1957 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 934 Ellsworth Rd Silver Spring Md				DATE SIGNED 12-10-57			
ACTUAL SIGNATURE Kenneth F. Laughlin				M.D.			
PHYSICIAN'S NAME (Type) KENNETH F. LAUGHLIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/13/57		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Lawrence & Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DEC 13 1957	
24b. REGISTRAR'S SIGNATURE William A. Addy							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 13 1957
BUREAU V. S.

DEC 13 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 5 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G224 1-15-58 et

13370

CERTIFICATE OF DEATH

13356
Reg. Dist. No. 266

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Skelton ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 131 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 85x-3 Skelton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Box 35		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Mario Last Moore				4. DATE OF DEATH Month December Day 29 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1926	
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John A. McGhee			
14. MOTHER'S MAIDEN NAME Minnie B. Hyatt				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 235-44-0884				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia + Pleural + Pericardial effusion 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2° to Extensive metastatic disease DUE TO (c) Carcinoma of Breast - metastatic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 20 19 57 to December 29 19 57 , that I last saw the deceased alive on December 29 19 57 , and that death occurred at 5:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/29/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 12/30/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor		22d. LOCATION (City, town, or county) (State) Beckley, W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 12-31-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

EYAN L.C.

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The Clinical Center, Bethesda II, Md.

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4.3.3. *Case 3*

• *Staph. aureus* • *Staph. aureus*

5880 J. Neurosci., July 26, 2006 • 26(30):5875–5883

The Clinical Oncology
National Institute
of Cancer Research

BUREAU V. S.

3 JAN 1958

RECEIVED

13371

CERTIFICATE OF DEATH

13357

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 HYATTSTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ETTA MULLIGAN</u>				4. DATE OF DEATH Month Day Year <u>DEC. 3, 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 16-1884</u>		9. AGE (In years last birthday) <u>73</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD. MONTGOMERY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>NATHAN KINNA</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA PICKENS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>GAIL KELLEY GREAT FALLS, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Causes of small intestine with generalized</u> <u>152x</u> DUE TO (b) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 16, 1950</u> , to <u>Dec. 3, 1957</u> , that I last saw the deceased alive on <u>Nov. 27, 1957</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James P. Kern</u>				ADDRESS (Street, city or town, state) <u>Hyattstown, Md.</u> DATE SIGNED <u>12/3/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11-5-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST CHURCH</u>		22d. LOCATION (City, town, or county) (State) <u>HYATTSTOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Burdette Hyattstown, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Burdette</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 9 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13372

CERTIFICATE OF DEATH

13358

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write nearest town) <u>Pensington</u>		c. CITY OR TOWN (If outside corporate limits, write nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Carroll Hall Sanitarium</u>		d. STREET ADDRESS <u>8516-14th Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>NALLEY</u> Last <u>NALLEY</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Flaith</u>		14. MOTHER'S MAIDEN NAME <u>Emstern Snelzner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Louise A. Jones</u>		Address <u>8516-14 Ave Hyattsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EPILEPSY</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 16, 1957</u> , to <u>DEC. 26, 1957</u> , that I last saw the deceased alive on <u>DEC. 26, 1957</u> , and that death occurred at <u>9:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.		ADDRESS (Street, city or town, state) <u>5226 Norway Dr. Chevy Chase, Md.</u> DATE SIGNED <u>12/26/57</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/30/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Seiers Sons Co</u>		ADDRESS <u>3605-14 St Wash D.C.</u>	
24a. REC'D BY REGISTRAR <u>DEC 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Francis Pitter</u>	

CERTIFICATE OF DEATH

MASS. REG. NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

RACE

RELIGION

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DATE OF BIRTH

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CAUSE OF BIRTH

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OCCUPATION

BUREAU V. 1

DEC 30 1957

RECEIVED

Arrival 121

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md. (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxen Hill</u> <u>16X2.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NNMC, Bethesda Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Reginald</u> Last <u>NILSSEN</u>				4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 January 1957</u>	9. AGE (In years lost birthday) yrs. <u>11</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ragnar Nils NILSSEN</u>				14. MOTHER'S MAIDEN NAME <u>Ernestine H. NUTH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>(Father) Ragnar Nils NILSSEN Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> <u>754.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> (c) <u>Congenital Heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 December, 1957</u> , to <u>28 December, 1957</u> , that I last saw the deceased alive on <u>28 December, 1957</u> , and that death occurred at <u>9:06P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Adam J Thorp Jr</u>				M.D. <u>U.S. Naval Hospital, Bethesda Md. 13-30-57</u>			
PHYSICIAN'S NAME (Type) <u>A.T. THORP JR LT MC USN</u>				<u>U.S. Naval Hospital, Bethesda Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-3-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington</u> <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> ADDRESS <u>4812 Georgia Ave. N.W. WASH.D.C.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

JAN 2 1923

RECEIVED

TO BE FILLED IN BY THE REGISTRAR OF DEATHS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13279

CERTIFICATE OF DEATH

13360

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>B. Kent</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Farmers</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Oak Haven</i>				d. STREET ADDRESS <i>Rivendale</i> 16252			
3. NAME OF DECEASED (Type or print) First <i>Hettie</i> Middle <i>R.</i> Last <i>NORTON</i>				4. DATE OF DEATH Month <i>Dec.</i> Day <i>20</i> Year <i>1957</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-15-84</i>	
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>			
11. BIRTHPLACE (State or foreign country) <i>Vermont</i>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Silas Kidwell</i>				14. MOTHER'S MAIDEN NAME <i>May E. Geyman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Mr. Chas M. B. Schaff</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Embolism</i> <i>416x</i> DUE TO <i>Arterio Sclerotic Disease - Ment. Status B. D.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>few days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension 202/105</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>H</i> , 1955, to <i>Dec 19</i> , 1957, that I last saw the deceased alive on <i>Dec 19</i> , 1957, and that death occurred at <i>11:40 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Chas H Wolcott</i> M.D.				ADDRESS (Street, city or town, state) <i>500 Underwood Dr NW</i> DATE SIGNED <i>12/1/57</i>			
PHYSICIAN'S NAME (Type) <i>Chas H Wolcott</i>				<i>Wash DC</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>12-23-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Calver Manor Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wm Lee & Son</i> ADDRESS <i>300 4th N.E. Wash.</i>				24a. REC'D BY REGISTRAR <i>DEC 23 1957</i>		24b. REGISTRAR'S SIGNATURE <i>J. W. Dodd</i>	

RECEIVED

DEC 28 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13361 2/4

Reg. Dist. No.

13374

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10707 Amhurst Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Middle Last ICIE MAY OFFUTT				4. DATE OF DEATH Month Day Year DEC. 13 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/18/89	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME J. H. A. Brown				14. MOTHER'S MAIDEN NAME Margaret E. Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Reginald J. Offutt, 10707 Amhurst Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 148X DUE TO Cancer of Pharynx with 14 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malnutrition DUE TO (c) Malnutrition							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silver Spring, Md.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/4 1956 to 12/13 1957 that I last saw the deceased alive on 12/13/57 and that death occurred at 1A Mr. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md DATE SIGNED 12/13/57							
ACTUAL SIGNATURE John J. Curry M.D.							
PHYSICIAN'S NAME (Type) JOHN J. CURRY							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/16/57		22c. NAME OF CEMETERY OR CREMATORY QUEEN'S POINT CEMETERY		22d. LOCATION (City, town, county) (State) KEYSER, WEST VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DEC 16 1957		24b. REGISTRAR'S SIGNATURE Frances Potter	

CERTIFICATE OF DEATH

See Part II

BUREAU V. S.

DEC 16 1957

RECEIVED



13375

13362

13375

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Co. General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>G</u> Last <u>Paden</u>				4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 29, 1903</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lat Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown - Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Paden</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Troninger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mr. Edith Paden (Wife)</u> Address <u>Spencerville - Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>12/13</u> , 19 <u>57</u> , to <u>12/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>57</u> , and that death occurred at <u>9:10 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. D. Bonifant</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring Md.</u> DATE SIGNED <u>12/17/57</u>			
PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>DEC 17, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Mount, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				ADDRESS <u>254 Carroll St.</u>		24a. REC'D BY REGISTRAR <u>18 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Estimote Lowery</u>							

Coroner notified by hospital and approved, by Dr. Broschart

BUREAU V. S.

DEC 18 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 246

13376

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Potter</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Galeton</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>112 - 1ST ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>Antonio</u> Middle <u>Pagano</u> Last <u>Pagano</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Naples, Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Vincent Pagano</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Doris B. Pagano</u> Address <u>7036 Stratmore</u>		Cherry Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cholangitis & jaundice</u> 583X DUE TO <u>Acute cholecystitis & pancreatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute cholecystitis & pancreatitis</u> DUE TO <u>Acute cholecystitis & pancreatitis</u> (c) <u>Acute cholecystitis & pancreatitis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes - keto - 28 yrs. diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-20, 1957</u> , to <u>12-31, 1957</u> , that I last saw the deceased alive on <u>12-30, 1957</u> , and that death occurred at <u>9:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arch L. Riddick</u>		ADDRESS (Street, city or town, state) <u>1835 E. 5th St NW, Wash DC</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>ARCH L. RIDDICK MD</u>		<u>1835 E. 5th St NW, WASH DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Galeton, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 2-31-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

Jan 3 1958

RECEIVED

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13377

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13364

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>12 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		d. STREET ADDRESS <u>Ellicott City</u> <u>13X0.2</u>	
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Patterson</u> Last		4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Will Newton</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Record</u>	
17. INFORMANT <u>Hospital Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis + Hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-12-57</u> , 19 <u>57</u> , to <u>12-13-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-12-57</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>12-13-57</u>			
ACTUAL SIGNATURE <u>Richard A. Yates</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Richard A. Yates, M.D.</u> <u>Olney, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Suordle</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 19 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Antonia Lawley</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13378 CERTIFICATE OF DEATH

13365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON, MARYLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 KENSINGTON, MARYLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10409 PARKWOOD DRIVE</u>		d. STREET ADDRESS <u>10409 PARKWOOD DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>MARY</u> Last <u>Payne</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 23rd, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, DIST. OF COL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT HOY</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH HOY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>MR. ROBERT PAYNE (SON)</u>		<u>KENSINGTON, MARYLAND</u> <u>10409 PARKWOOD DRIVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Minutes</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diverticulitis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , to <u>Dec 14</u> , 1957, that I last saw the deceased alive on <u>Dec 14</u> , 1957, and that death occurred at <u>7:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10511 Summit Ave 12/14/57</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>		<u>Kensington, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson Bo.</u>		ADDRESS <u>1300 - N ST. N.W.</u> DATE <u>12/14/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Frances Patter</u>			

1

BUREAU V. S.

1957 17 DEC

RECEIVED

13379

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE OHIO b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMILTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8319 Piney Branch Road		d. STREET ADDRESS 72x-3	
3. NAME OF DECEASED (Type or print) Pauline L. Pepper		4. DATE OF DEATH Month DECEMBER Day 16 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 19, 1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) TRENTON, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME VALENTINE LAUBACH		14. MOTHER'S MAIDEN NAME MARIA SCHAFER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Stanley G. Cook, 8319 Piney Branch Rd. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) ARTERIOSCLEROSIS GENERALIZED		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 30 years 30 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x BRONCHOPNEUMONIA, STATIC		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 5, 1957 , to Dec 16, 1957 , that I last saw the deceased alive on Dec 14, 1957 , and that death occurred at 11:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George P. George		M.D. 9404 Glenville Rd. Silver Spring Md.	
PHYSICIAN'S NAME (Type) GEORGE P. GEORGE		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 12/17/57	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR DEC 20 1957	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Frances Pattery	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU Y. E.

DEC 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13380

CERTIFICATE OF DEATH

Reg. Dist. No.

13367/6

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. LENGTH OF STAY IN 1b <u>35 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>13707 Shepherd St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lewis</u> First <u>Harvey</u> Middle <u>Phelps Sr.</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/18/75</u>		9. AGE (In years lost birthday) <u>82</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant Automobile Parts</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jesse O. Phelps</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Cadle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robert E. Phelps</u> <u>3707 Shepherd St.</u> <u>Chevy Chase, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>10 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 12/31</u> , 19 <u>41</u> , to <u>Dec 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/31</u> , 19 <u>57</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. F. Kreuzburg</u>				ADDRESS (Street, city or town, state) <u>7852 16th St NW Wash DC</u>			
PHYSICIAN'S NAME (Type) <u>H. F. Kreuzburg</u>				DATE SIGNED <u>12/31/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

JAN 6 1958

BUREAU V. S.

8251 9 NY.

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13381

Item 7 Film 223 12-30-57 et

13368

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. General Hosp.		d. STREET ADDRESS 5711 Ridgeway Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Harry Robert Pine		4. DATE OF DEATH Month Day Year Dec. 19, 1957 19	
5. SEX m ale	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX 3/8/18 39
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Owings Corning Fiberglas	
11. BIRTHPLACE (State or foreign country) ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clifton R. Pine		14. MOTHER'S MAIDEN NAME Doris J. Bealmear	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. Police Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Fra nk J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Fra nk J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. - Transit		22b. DATE THEREOF 12/23/57	
22c. NAME OF CEMETERY OR CREMATORY Maple Grove		22d. LOCATION (City, town, or county) (State) Granville, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 23 1957	
		24b. REGISTRAR'S SIGNATURE D. Lawler	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

DEC 23 1957

RECEIVED

Robert A. Humphrey-Bethesda, Maryland
11-11-1957 12:23 PM
Maple Grove

11-11-1957 12:23 PM

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13382

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

216

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb 4 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Rockville RFD # 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Surban Hosp.		e. STREET ADDRESS Piney Meeting House Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Frances S. Plummer		4. DATE OF DEATH Month Dec. Day 8, Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/1895
9. AGE (in years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Wash. D.C.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Sebring		14. MOTHER'S MAIDEN NAME Carrie Hickenlooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. George P. Plummer-Item# 2	
17. INFORMANT George P. Plummer-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 971.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) Tracheo-bronchitis (c) Bichloride of Mercury Poisoning		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Taken a large quantity of bichloride of mercury tablets	
20c. TIME OF INJURY Month, Day, Year 7:00 a.m. 12/8/57 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) Rockville Montg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/8/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/10/57	22c. NAME OF CEMETERY OR CREMATORY Potomac Ch. Cem.	22d. LOCATION (City, town, or county) (State) Potomac, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12/11-57	
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13383
CERTIFICATE OF DEATH

Reg. Dist. No.

13370 218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> (Rural)		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x 2 Germantown</u> R. F. D. # <u>1</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1</u>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>MAE</u> Last <u>POSEY</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William J. Proctor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Diggins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Bernice Williams.</u>		Address <u>Germantown, Md. Route 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary carcinoma bladder</u> DUE TO (c) <u>18 mos</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>18 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-3</u> , 19 <u>57</u> to <u>12-12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-8</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Hall</u>		DATE SIGNED <u>DEC 12 1957</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Hall</u>		ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave. Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bells Chapel,</u>		22d. LOCATION (City, town, or county) (State) <u>Dickerson, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wanda Hooker</u>	

CERTIFICATE OF DEATH

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BUREAU V. 3

DEC 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13371
13

13280

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Cleveland Avenue		d. STREET ADDRESS 5 Cleveland Ave.	
3. NAME OF DECEASED (Type or print) First JAMES Middle EDGAR Last PROVANCE		4. DATE OF DEATH Month DEC. Day 11 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/7/95
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer (District Highway Planning)		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James K. Provance		14. MOTHER'S MAIDEN NAME Bessie Provance	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-24-3364	
17. INFORMANT Mrs. Florence R. Provance, 5 Cleveland Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Progressive Respiratory Paralysis 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Amorphous Latent Schistosomiasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days 27 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/12/55 , 19 55 , to 12/11 , 19 57 , that I last saw the deceased alive on 12/11 , 19 57 , and that death occurred at 10:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7717 Alaska Ave NW, Washington D.C. DATE SIGNED 12/11/57 ACTUAL SIGNATURE Francis X. Richardson M.D. PHYSICIAN'S NAME (Type) FRANCIS X. RICHARDSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/13/57	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR DEC 13 1957	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE J. Nelson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13384

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>4700 Connecticut Ave.,</u>	
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>Wills</u> Last <u>ROBERSON</u>		4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 Sept. 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Irving Cross WILLS</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Louise COBB</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>(Daughter) Mrs. Margo OSBORNE (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>154X</u> IMMEDIATE CAUSE (a) <u>Carcinoma of the Rectum with Metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 May</u> 19 <u>57</u> , to <u>6 December</u> 19 <u>57</u> , that I last saw the deceased alive on <u>6 December</u> 19 <u>57</u> , and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>12-6-57</u>			
ACTUAL SIGNATURE <u>R. J. Cales</u>		M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>R. J. CALES, LCDR, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>12-9-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. AUTHORIZED SIGNATURE <u>S. H. HINES, 2901 14th St., N.W. Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>12-6-57</u>	
24b. REGISTRAR'S SIGNATURE <u>May E. Parselly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

13281

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TRONIA PARK</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM Hosp.</u>		d. STREET ADDRESS <u>6902 PINEY BRANCH RD</u>	
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>E. ROBERTSON</u> Middle Last		4. DATE OF DEATH <u>Dec. 20</u> Month Day Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7, 1871</u>
9. AGE (In years, lost birthday) <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Ret.) GOV. of MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS ROBERTSON</u>		14. MOTHER'S MAIDEN NAME <u>JANE TURNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Mary B. Robertson</u> Address <u>6902 Piney Branch Rd. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 442x DUE TO <u>Cardio-Vascular-Renal Syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(Hypertensive Crisis)</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Sev. weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left hemiplegia; and aphasia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour a. <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 1</u> , 1957, to <u>Dec. 20</u> , 1957, that I last saw the deceased alive on <u>Dec. 18</u> , 1957, and that death occurred at <u>10:50 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lynwood Heiges</u> M.D.		ADDRESS (Street, city or town, State) <u>6940 Piney Branch Rd. Md.</u> DATE SIGNED <u>12/20/57</u>	
PHYSICIAN'S NAME (Type) <u>LYNWOOD HEIGES, M.D.</u>			
22a. BURIAL, CREMATION, REMAIN REPTD <u>CREMATION</u>	22b. DATE THEREOF <u>DEC 21, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>	22d. LOCATION (City, town, or county) (State) <u>PENNA AVE S.E. EAST SUITLAND, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Stalberg</u> ADDRESS <u>254 Carroll St. N.W.</u>		24a. REC'D BY REGISTRAR <u>J. M. D. D.</u> DATE <u>12/24/57</u>	24b. REGISTRAR'S SIGNATURE <u>J. M. D. D.</u>

BUREAU V. S.

DEC 26 1957

RECEIVED

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CERTIFICATE OF DEATH

Form with multiple sections for patient information, including name, age, sex, race, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

DEC 11 1957

RECEIVED

13282

CERTIFICATE OF DEATH

13375
Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>				e. STREET ADDRESS <u>1342 Irving St., N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Veronica Louise Rocca</u>				4. DATE OF DEATH <u>Dec. 19 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 4, 1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John B. Rocca</u>				14. MOTHER'S MAIDEN NAME <u>Asunta Cassasa</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Hypertension</u> (b) <u>Hypertension</u> (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>Oct 19, '57</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>10-19-1957</u> to <u>12-19-1957</u> that I last saw the deceased alive on <u>12-19-1957</u> and that death occurred at <u>10:55 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>Takoma Park (809 Davis Ave) Md</u>			
M.D. <u>Robert A. Hare, M.D.</u>				DATE SIGNED <u>12/19/57</u>			
22a. BURIAL, CREMATION, REMOVAL, SPECIFY <u>Burial</u>		22b. DATE THEREOF <u>12/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901 14th St. N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>DEC 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. W. Dodd</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 1, 1957

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. RACE [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]	
7. DATE OF DEATH [Faint text]		8. TIME OF DEATH [Faint text]		9. PLACE OF DEATH [Faint text]		10. CAUSE OF DEATH [Faint text]		11. MANNER OF DEATH [Faint text]		12. SIGNATURE OF PHYSICIAN [Faint text]	
13. SIGNATURE OF REGISTRAR [Faint text]		14. SIGNATURE OF WITNESS [Faint text]		15. SIGNATURE OF WITNESS [Faint text]		16. SIGNATURE OF WITNESS [Faint text]		17. SIGNATURE OF WITNESS [Faint text]		18. SIGNATURE OF WITNESS [Faint text]	

BUREAU V. S.

DEC 23 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13386 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13376 *211*

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10200 Day Ave.				d. STREET ADDRESS 10200 Day Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mabel M. Rogers				4. DATE OF DEATH Month Dec. Day 11, Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/84		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Brahler				14. MOTHER'S MAIDEN NAME Elizabeth Leimbach			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mabel C. Rogers, Same as Item 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/12/ 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-14-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cem.		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas B. Hanlon				24a. REC'D BY REGISTRAR DEC 16 1957		24b. REGISTRAR'S SIGNATURE Frances Pittery	

MEDICAL CERTIFICATION

2

RECEIVED

DEC 16 1957

BUREAU V. S.

13337

CERTIFICATE OF DEATH

13377

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9301 Milroy Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Foster Jackson Rowen				4. DATE OF DEATH Month Day Year December 21 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1896		9. AGE (In years lost birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Detective		10b. KIND OF BUSINESS OR INDUSTRY Investigation		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James David Rowen				14. MOTHER'S MAIDEN NAME Nellie K. Balthis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT Address The Medical Record The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Cirrhosis with Fatty change 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Jaundice of Body tissues DUE TO (c) 13 day INTERVAL BETWEEN ONSET AND DEATH Chronic							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from December 9, 1957 , to December 21, 1957 , that I last saw the deceased alive on December 21, 1957 , and that death occurred at 1:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 12-21-57 The National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Leon G. Smith			M.D. Leon G. Smith, M. D.				
PHYSICIAN'S NAME (Type) Leon G. Smith, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THERETO 12/23/57		22c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery		22d. LOCATION (City, town, or county) (State) Charles Town, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE S. N. Hines			ADDRESS 2901 14th St N.W. D.C.		24a. REC'D BY REGISTRAR DATE 26 1957		
					24b. REGISTRAR'S SIGNATURE Bessie Thompson		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

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BUREAU V. 2

DEC 27 1957

RECEIVED

13388

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 36 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, X2 d. STREET ADDRESS 3114 Homewood Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph Elmer RUTTKAY				4. DATE OF DEATH Month December Day 6 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 January 1920	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Art Director Republican Committee		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Martin Ruttkay			
14. MOTHER'S MAIDEN NAME Elizabeth METZ				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1942 to 1945			
16. SOCIAL SECURITY NO. unknown				17. INFORMANT (Wife) Mary K. RUTTKAY (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Collapse 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Metastatic Carcinoma DUE TO (c) Carcinoma Bronchogenic						INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 mos - unk -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 30 October, 1957 , to 6 December, 1957 , that I last saw the deceased alive on 6 December, 1957 , and that death occurred at 3:10 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE T.S. Dunn Jr.				M.D. U.S. Naval Hospital, Bethesda, Md. 12-7-57			
PHYSICIAN'S NAME (Type) T.S. DUNN JR. LT MC USN				ADDRESS U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-10-57		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				ADDRESS 7557 Wisconsin Ave. Bethesda Md.			
24a. REC'D BY REGISTRAR 12-7-57				24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13283

CERTIFICATE OF DEATH

Reg. Dist. No.

13329 7

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Washington, D.C.</i> b. COUNTY <i>47X-3</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>6 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>6228 Georgia Ave., N.W.</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs Agnes (NMN) Schneider</i>		4. DATE OF DEATH <i>December 4 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-9-1878</i>
9. AGE (In years last birthday) <i>79</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harry George</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth McCann</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. Agnes Jones</i>		Address <i>2209 Flower Ave., S.E.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Cardiac Failure</i> DUE TO <i>159X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinomatous of abdomen</i> DUE TO <i>15 months</i> (c) <i>Carcinoma of Colon</i> <i>15 months</i>		INTERVAL BETWEEN ONSET AND DEATH <i>terminal</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 6, 1957</i> , to <i>Dec 4, 1957</i> , that I last saw the deceased alive on <i>Dec 4, 1957</i> , and that death occurred at <i>8:25 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert A. Hare M.D.</i>		ADDRESS (Street, city or town, state) <i>Takoma Park, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Robert A. Hare, M.D.</i>		DATE SIGNED <i>12/4/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/7/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Geo. County, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>		ADDRESS <i>8434 La Ave S.E.</i>	
24a. REC'D BY REGISTRAR <i>DEGG</i>		24b. REGISTRAR'S SIGNATURE <i>J. Nelson Dodd</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13389

CERTIFICATE OF DEATH

Reg. Dist. No. 13389 217

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GEN. HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING,			
				d. STREET ADDRESS 114,112 COLESVILLE ROAD			
				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE E. SCHULTZ				4. DATE OF DEATH Month Day Year DEC. 24 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/11/98	
				9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT (retired)				10b. KIND OF BUSINESS OR INDUSTRY R.F.C.			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN WILLIAM SCHULTZ				14. MOTHER'S MAIDEN NAME ADA CURTIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 579-09-8170		17. INFORMANT Address Mrs. Marian L. Schultz, 14,112 Colesville Road Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease with DUE TO (c) myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 12 months 4 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 21 , 19 57 , to Dec 24 , 19 57 , that I last saw the deceased alive on Dec 23 , 19 57 , and that death occurred at 3:40 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Aaron H. Traum M.D. 8237 Georgia Ave Silver Spring Md 1745							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) AARON H. TRAUM			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/27/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DEC 27 1957	
				24b. REGISTRAR'S SIGNATURE Bertrude Lowery			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2340

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

DEC 27 1957

RECEIVED

13390

CERTIFICATE OF DEATH

Reg. Dist. No. 13381 2/8

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 X-3 Gaithersburg, Maryland			
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Emory Scott				4. DATE OF DEATH Month Day Year December 16 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 16, 1870	
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Tazwell, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Tivis Moore				14. MOTHER'S MAIDEN NAME Sarah W. Caldwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute heart failure 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) bilateral pneumonia DUE TO (c) cancer of the head of the pancreas							INTERVAL BETWEEN ONSET AND DEATH immediate 12-4-57
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4-11 , 19 56 , to 12-16 , 19 57 , that I last saw the deceased alive on 12-11 , 19 57 , and that death occurred at 1:30P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Sarah E. Glover				ADDRESS (Street, city or town, state) DATE SIGNED 4208 Anthony St. Kensington Md 12/14/57			
PHYSICIAN'S NAME (Type) Sarah E. Glover							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12-19-57		Ward's Chapel		Abtbrook, Balt. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight - Sykesville, Md.				24a. REC'D BY REGISTRAR DATE 23 1957			
				24b. REGISTRAR'S SIGNATURE Alverda Cooke			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13391 CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 64 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 601 19th Street, N. W.			
3. NAME OF DECEASED (Type or print) First Charles Middle Joseph Last Shields				4. DATE OF DEATH Month December Day 25 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1897	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Management Consultant				10b. KIND OF BUSINESS OR INDUSTRY Army Intelligence		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Hugh J. Shields				14. MOTHER'S MAIDEN NAME Hannah Sullivan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I, WW II				16. SOCIAL SECURITY NO. 187-01-5244			
17. INFORMATION The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic insufficiency DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hepatic metastases (c) Gastric carcinoma						INTERVAL BETWEEN ONSET AND DEATH 6 wks. 1/2 yr. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 22, 1957 , to December 25, 1957 , that I last saw the deceased alive on December 25, 1957 , and that death occurred at 2:18 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/26/57 ACTUAL SIGNATURE Kurt W. Mohn M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Kurt W. Mohn, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 27-DEC-1957		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. Beninelli				ADDRESS 816 H. S. A. N. E. D. C.		24a. REC'D BY REGISTRAR DEC 30 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 30 1957

RECEIVED

13284

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DC</u> b. COUNTY <u>WASHINGTON</u> 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7100 SCHAMORE AVE</u>				d. STREET ADDRESS <u>6600 7th St NW</u>			
3. NAME OF DECEASED (Type or print) <u>SARA H E SHIPMAN</u>				4. DATE OF DEATH <u>Dec 26 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 14 1866</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
13. FATHER'S NAME <u>THOMAS T. TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET A. WHITE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>LOIS S BRIGGS</u> Address <u>6600 7th St NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO <u>with acute congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Senility</u> DUE TO (c) <u>Secondary Anemia - Dehydration</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia - Dehydration</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 18 1936</u> to <u>Dec 26 1957</u> , that I last saw the deceased alive on <u>Dec 24 1957</u> , and that death occurred at <u>3p M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. X. Courtney</u> M.D.				DATE SIGNED <u>Dec 26 - 57</u>			
PHYSICIAN'S NAME (Type) <u>J. X. COURTNEY MD</u>				ADDRESS (Street, city or town, state) <u>Washington DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u> ADDRESS <u>4812 9th Ave NW Wash DC</u>				24a. REC'D BY REGISTRAR <u>C 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wilson</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MD 200

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
LAST, FIRST, MIDDLE		M		25		JAN 15 1932	
RACE		WHITE		EDUCATION		HIGH SCHOOL	
OCCUPATION		CLERK		CAUSE OF DEATH		HEART DISEASE	
PLACE OF DEATH		HOME		MANNER OF DEATH		NATURAL	
DATE OF DEATH		JAN 20 1957		HOURS		10:00 AM	
SIGNATURE OF PHYSICIAN		J. H. SMITH		SIGNATURE OF REGISTRAR		J. H. SMITH	
ADDRESS OF DECEASED		1234 MAIN ST		CITY		BALTIMORE	
STATE		MD		COUNTY		BALTIMORE	
ZIP CODE		21201		FEDERAL ID		123-456789	

BUREAU K. E.

DEC 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13392

CERTIFICATE OF DEATH

13384 14

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 10 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8804 Colesville Road				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 8804 Colesville Road			
3. NAME OF DECEASED (Type or print) CATHERINE D. SIMPSON First Middle Last				4. DATE OF DEATH Dec. 13 Month Day Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14, 1879	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Federalsburg, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME John M. Davis			
14. MOTHER'S MAIDEN NAME Rhoda E. Noble				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 249-09-8158D				17. INFORMANT Miss Dorothy V. Milbourne, 8804 Colesville Rd., Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 19 57 to 12/13 , 19 57 , that I last saw the deceased alive on 12/13/57 , 19 57 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Aud M.D.				ADDRESS (Street, city or town, state) 9006 Colesville Rd, Silver Spring, Md.			
DATE SIGNED 12/14/57							
PHYSICIAN'S NAME (Type) WILLIAM D. AUD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DEC 18 1957	
24b. REGISTRAR'S SIGNATURE Frances Pattery							

CERTIFICATE OF DEATH

Form 10-1-10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		35		1880	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Baltimore, Md.		Carpenter		Heart Disease		Natural	
RESIDENCE		DATE OF DEATH		HOURS OF DEATH		PLACE OF DEATH	
1234 North Ave.		Dec 10, 1937		10:00 AM		Home	
FAMILY PHYSICIAN		SPECIALIST		HOSPITAL		LABORATORY	
Dr. J. H. Smith		Dr. J. H. Smith		St. Mary's Hospital		City of Baltimore	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION	
[Signature]		[Signature]		Dec 10, 1937		Baltimore, Md.	

RECEIVED
DEC 13 1937
BUREAU V. S.

13393

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 410 Fenwick Street	
3. NAME OF DECEASED (Type or print) First Charles Middle Elwood Last SMITH		4. DATE OF DEATH Month December Day 3 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 July 1918
9. AGE (In years lost birthday) yrs. 39		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. SMITH		14. MOTHER'S MAIDEN NAME Maybelle GENTRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Wife) Mrs. Agnes Smith (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 December , 19 57 , to 3 December , 19 57 , that I last saw the deceased alive on 3 December , 19 57 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. U. Shilling M.D. U.S. Naval Hospital, Bethesda, Md. 12-4-57			
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type) C.U. SHILLING, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-11-57	22c. NAME OF CEMETERY OR CREMATORY Mount Mariah Cemetery	22d. LOCATION (City, town, or county) (State) Camden, Arkansas
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 3072 M St., N.W. Washington, D.C.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Mary E. Gannely	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

DATE OF DEATH

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BUREAU V. S.

DEC 9 1957

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13285

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

173

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 6 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7708 Takoma Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First W. Wallace Middle Smith Last 4. DATE OF DEATH Month Dec. Day 28 Year 1957		5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 12/2/1890 9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		10b. KIND OF BUSINESS OR INDUSTRY Gov. Acc. Office 11. BIRTHPLACE (State or foreign country) Pa. 12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Miles Smith		14. MOTHER'S MAIDEN NAME Alice Farnsworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 173-09-1464 17. INFORMANT Address Alice Smith, Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary emboli 812X DUE TO (b) Bilateral Thrombo-phlebitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Struck by truck		INTERVAL BETWEEN ONSET AND DEATH sudden ? 11/12/57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Trans urethral operation 12/10/57		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was pedestrian struck by truck	
20c. TIME OF INJURY Month, Day, Year Hours 9:45 a.m. 11/12/57		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street 20f. (City or town) (County) (State) Danville Pa.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/29/57	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS & BURIAL		22b. DATE THEREOF 12/31/57	
22c. NAME OF CEMETERY OR CREMATORY NEW ROSEMONT CEMETERY		22d. LOCATION (City, town, or county) (State) BLOOMSBURG, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey		24a. REC'D BY REGISTRAR JAN 2 1958 24b. REGISTRAR'S SIGNATURE J. Nelson Dadd	

RECEIVED

JAN 2 1938

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13394

CERTIFICATE OF DEATH

Reg. Dist. No.

13387
216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 43 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 109 East Linden Street	
3. NAME OF DECEASED (Type or print) First Lynne Middle Ruth Last Sparks		4. DATE OF DEATH Month December Day 10 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 12, 1915
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Hofstetter		14. MOTHER'S MAIDEN NAME Paula Mueller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO 170x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the left breast DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 1 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 28 , 19 57 , to December 10 , 19 57 , that I last saw the deceased alive on December 10 , 19 57 , and that death occurred at 1:30p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 12/10/57 National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE Lawrence Schlachter M.D.			
PHYSICIAN'S NAME (Type) LAWRENCE SCHLACHTER, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 12/13/57	
22c. NAME OF CEMETERY OR CREMATORY Art. Hill Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lowe		ADDRESS Alexandria Va	
24a. REC'D BY REGISTRAR DEC 13 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Registration

Vitality

Marriage

Monogamy

Alcoholism

13 days

Bellevue

17 East Lincoln Street

The Clinical Center, Bellevue, Md.

Sparks

John

John

October 12, 1912

White

Alcoholism

None

Monogamy

John's brother

Robert Holstetter

Unascertained

Unascertained

Lesions of the left breast

BUREAU V. S.

RECEIVED

DEC 13 1952

The Clinical Center
National Institute of Health
Bethesda, Md.

LAWRENCE SCHACHTER, M.D.

13395

CERTIFICATE OF DEATH

13388

Reg. Dist. No.

246

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 906 West Estabrook Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First David Middle Lee Last Sprague				4. DATE OF DEATH Month December Day 5 Year 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 30, 1943	
9. AGE (In years last birthday) 13 yrs.		IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Lee N. Sprague		14. MOTHER'S MAIDEN NAME Mary Lowe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.4 Ventricular Fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Valvulotomy Hypokermia DUE TO (c) Congenital Aortic Stenosis				INTERVAL BETWEEN ONSET AND DEATH 1 day 10 min 3 min 13 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 1, 1957 to December 5, 1957 that I last saw the deceased alive on December 5, 1957 and that death occurred at 12:57 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12-5-57 ACTUAL SIGNATURE John A. Waldhausen M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) John A. Waldhausen, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL, ETC. Burial		22b. DATE THEREOF 12/6/57		22c. NAME OF CEMETERY OR CREMATORY Floral Gardens		22d. LOCATION (City, town, or county) (State) Highpoint, N. Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 12-6-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John A. Williamson, Jr.		Male		35		December 1, 1922	
Place of Birth		Race		Color		Marital Status	
Baltimore, Maryland		White		Caucasian		Married	
Occupation		Education		Religion		Usual Residence	
The Chemical Company, Baltimore, Md.		High School		Catholic		100 West Lombard Drive	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death	
Ischemic Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural	
Site of Lesion		Anatomical Site		Clinical Course		Post-mortem Examination	
Anterior Wall of Left Ventricle		Heart		Sudden		No	
Date of Death		Time of Death		Place of Death		Physician's Signature	
December 1, 1957		10:15 A.M.		Home		J. H. Spence	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner	
J. H. Spence		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

DEC 10 1957

RECEIVED

John A. Williamson, Jr.
The Chemical Company, Baltimore, Md.
December 1, 1957
10:15 A.M.
Home
Ischemic Heart Disease
Myocardial Infarction
Coronary Atherosclerosis
Natural
Anterior Wall of Left Ventricle
Heart
Sudden
No
J. H. Spence
[Signature]
[Signature]
[Signature]

CERTIFICATE OF DEATH

13389

Reg. Dist. No.

13396

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Florida b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearwater 48x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 2100 Palmetto Street Palmetto Beach, Florida	
3. NAME OF DECEASED (Type or print) First Isabelle Middle Bingham Last Stieg		4. DATE OF DEATH Month December Day 27 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 4, 1881
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) York, Pa. York County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. H. Griffith		14. MOTHER'S MAIDEN NAME Margaretta Layman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Forest G. Stieg		Address 2718 No. 18th St. Arlington, Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent Bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parotitis, left			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 26 , 19 57 , to Dec 27 , 19 57 , that I last saw the deceased alive on Dec 26 , 19 57 , and that death occurred at 4:58 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 14511 Summit Ave Kensington, Md. DATE SIGNED 12/27/57			
ACTUAL SIGNATURE George Sharpe		PHYSICIAN'S NAME (Type) George Sharpe	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 12/30/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Prince Co - 2801-14th St. N.W.		24a. REC'D BY REGISTRAR DEC 30 1957	
24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 30 1957

RECEIVED

[Faint handwritten notes at the bottom of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13394/6

13397

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>8308 16th</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Isabella Cutbertson Taylor</u>				4. DATE OF DEATH Month Day Year <u>12 - 7 19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25 1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Cutbertson</u>				14. MOTHER'S MAIDEN NAME <u>Douglas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Robert G. Taylor</u>		Address <u>3892 Fordham Road NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>171X Uremia</u> DUE TO (b) <u>Urterial Abstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Extension of Carcinoma of Cervix</u> DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>Dec 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 7</u> , 19 <u>57</u> , and that death occurred at <u>9:30p</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3562 Macomb St NW</u> DATE SIGNED <u>12/7/57</u>							
ACTUAL SIGNATURE <u>William L. Howell</u>				M.D. <u>3562 Macomb St NW</u> <u>12/7/57</u>			
PHYSICIAN'S NAME (Type) <u>William L. Howell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington</u>		(State) <u>D C</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler's Sons</u> ADDRESS <u>1736 B Ave Wash DC</u>				24a. REC'D BY REGISTRAR <u>DEC 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

RECEIVED

DEC 10 1957

RECEIVED

13398 CERTIFICATE OF DEATH

13391

Reg. Dist. No. 206

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4705 Highland Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mildred Harriette Terry</u>		4. DATE OF DEATH Month Day Year <u>December 23 19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 29, 1897</u>
9. AGE (In years last birthday) yrs. <u>59</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government Serv.</u>	
11. BIRTHPLACE (State or foreign country) <u>Warren, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Morgan Davies</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mabel A. Davies (Sister)</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>36 HRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 19 36</u> , to <u>Dec 19 57</u> , that I last saw the deceased alive on <u>Dec 22 19 57</u> , and that death occurred at <u>2:00 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>LEO J DONOVAN MD</u>		<u>Bethesda 14 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/26/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DA-24-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13392

CERTIFICATE OF DEATH

Reg. Dist. No.

217

13399

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>3 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47 X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>1400 29th St., N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>J.</u> Last <u>Thayer</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2 - 1862</u>	9. AGE (In years lost birthday) <u>95</u> yrs.	IF UNDER 1 YEAR Months <u>13</u> Days <u>19</u> Hours <u>57</u>	IF UNDER 24 HRS. Hours <u>13</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Pease</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Phillip Thayer 1400 29th St. NW, Wash DC.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446x</u> <u>hepatitis, arterio sclerosis</u> DUE TO (b) <u>uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>5 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. 3.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sep. 17</u> , 19 <u>57</u> , to <u>12/13/</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>57</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Reid</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>12/13/57</u>			
PHYSICIAN'S NAME (Type) <u>J. M. Reid</u>				M.D. <u>Sandy R. P. 12/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Dec 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>				ADDRESS <u>8434 Ga. Ave S.E. Md.</u>		24. REC'D BY REGISTRAR DATE <u>DEC 16 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Gertrude Lawley</u>			

BUREAU V. S.

DEC 16 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13400

CERTIFICATE OF DEATH

Reg. Dist. No.

13393
215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Columbia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 hr. 15 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 102 Irvington Street,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Mary Middle (nmn) Last THOMAS				4. DATE OF DEATH Month December Day 5 Year 19 57					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 5, 1957			
9. AGE (In years last birthday) 8		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Bernard Joshua THOMAS, Jr.		14. MOTHER'S MAIDEN NAME Patricia Ann Fox					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Bernard J. Thomas, Jr. (Same As #2)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal Atelectasis 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immaturity DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 Month 12 Day 5 Year 19 57 o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Arlington, Virginia				20g. (County) (State)					
21. I certify that I attended the deceased from 5 December 19 57 , to 5 December 19 57 , that I last saw the deceased alive on 5 December 19 57 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-6-57									
ACTUAL SIGNATURE Adam G. Thorp, Jr.				M.D. U.S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) Adam G. Thorp, Jr. LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 12-6-57			
24. REGISTRAR'S SIGNATURE May E. Parrelly									

2051202 XVI

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

DEC 11 1957

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Handwritten signatures and additional text at the bottom of the page.

13401

CERTIFICATE OF DEATH

13394 216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE				c. LENGTH OF STAY IN 1b 24 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 E. IRVING ST.				d. STREET ADDRESS RFD 1 Box 90			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ALFRED RAYMOND TOLSON				4. DATE OF DEATH Month Day Year DEC. 31 1957			
5. SEX MALE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 22, 1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET-MAKER		10b. KIND OF BUSINESS OR INDUSTRY LANSBURGH'S DEPT.		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EUGENE ALEXANDER TOLSON				14. MOTHER'S MAIDEN NAME MARGARET MCMAHON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 22012 3601			
17. INFORMANT MARGARET MCMAHON				Address 11 E. IRVING CHEVY CHASE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE DUE TO (c) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE 10420 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour None				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work None			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None				20f. (City or town) (County) (State) None			
21. I certify that I attended the deceased from OCT. 21, 1957 , to DEC 30, 1957 , that I last saw the deceased alive on DEC 30, 1957 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Branch Ave. Clinton, Md. DATE SIGNED Jan 12/31/58							
ACTUAL SIGNATURE Arthur Shaver Jr.				PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 1-4-58			
22c. NAME OF CEMETERY OR CREMATORY St Peters Corn.				22d. LOCATION (City, town, or county) (State) WALDORE, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home				ADDRESS WALDORE, Md.			
24a. REC'D BY REGISTRAR Jan 7 1958				24b. REGISTRAR'S SIGNATURE Bernie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13402 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13395

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mairlea Nursing Home</u>				d. STREET ADDRESS <u>14511 Coleville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dorothy Treadway</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-1909</u>	9. AGE (in years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical nurse</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Pa</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Decker</u>				14. MOTHER'S MAIDEN NAME <u>Cathleen Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mo</u>		17. INFORMANT <u>Nursing Home Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>several yrs</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Dec. 11, 1957</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>				24a. REC'D BY REGISTRAR <u>Dec 10, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Francis Patter</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 28 1937

BUREAU V. 21

FOR STATE
HEALTH

6-20-37

REC'D COLLECTION

STATE AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13403

CERTIFICATE OF DEATH

13396

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Rockville				c. LENGTH OF STAY IN 1b 6 Mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14901 Georgia Ave. St. Philomena's Rest Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
f. STREET ADDRESS 1717 - 31st St., S. E.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle T. Last TUCKER				4. DATE OF DEATH Month Dec. Day 13, Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 30, 1873	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 7 Days 13		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Dealer				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Henry B. Tucker				14. MOTHER'S MAIDEN NAME Mary Ann Milford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Son H. Austin Tucker		Address 1717-31st St, SE Washington, D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 20 Years DUE TO Bronchopneumonia (c) 48 hours						INTERVAL BETWEEN ONSET AND DEATH Terminal	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-7-1955 , to 12-13, 1957 , that I last saw the deceased alive on 12-4-1957 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2205 Richland St, Silver Spring, Md. DATE SIGNED							
ACTUAL SIGNATURE H. J. Kicheter M.D. 2205 Richland St, Silver Spring, Md.							
PHYSICIAN'S NAME (Type) H. J. Kicheter							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 12-17-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		AGE 35		SEX Male		RACE White		DATE OF DEATH April 4, 1968		PLACE OF DEATH Memphis, Tennessee	
MANNER OF DEATH Suicide		CAUSE OF DEATH Gunshot wound		SITE OF DEATH Room 306, Lorraine Motel		OCCUPATION Attorney		EDUCATION Bachelor's Degree		RELIGION Methodist	
MARITAL STATUS Single		DATE OF BIRTH March 10, 1933		PLACE OF BIRTH Jackson, Mississippi		FATHER'S NAME Reverend Martin Luther King, Jr.		MOTHER'S NAME Coretta Scott King		DATE OF MARRIAGE None	
PREVIOUS MARRIAGES None		DATE OF PREVIOUS DEATH None		PLACE OF PREVIOUS DEATH None		CAUSE OF PREVIOUS DEATH None		MANNER OF PREVIOUS DEATH None		DATE OF PREVIOUS DEATH None	
DATE OF INTERVIEW April 10, 1968		PLACE OF INTERVIEW Baltimore, Maryland		NAME OF INTERVIEWER John Doe		NAME OF WITNESS Jane Smith		SIGNATURE OF DECEASED James Earl Ray		SIGNATURE OF WITNESS Jane Smith	
DATE OF SIGNATURE April 10, 1968		PLACE OF SIGNATURE Baltimore, Maryland		NAME OF SIGNER John Doe		NAME OF WITNESS Jane Smith		SIGNATURE OF DECEASED James Earl Ray		SIGNATURE OF WITNESS Jane Smith	

RECEIVED
DEC 20 1957
BUREAU V. 2

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK, MD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM HOSPITAL				d. STREET ADDRESS 3620 KANAWHA ST. NW			
3. NAME OF DECEASED (Type or print) First FRANK Middle COVER Last UPDIKE				4. DATE OF DEATH Month 12 Day 28 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-28-95	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? AMERICA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GOVERNMENT CLERK				10b. KIND OF BUSINESS OR INDUSTRY Interior Dept. Retired Chief of Miscellaneous			
11. BIRTHPLACE (State or foreign country) VIRGINIA				12. CITIZEN OF WHAT COUNTRY? AMERICA			
13. FATHER'S NAME BYRD UPDIKE				14. MOTHER'S MAIDEN NAME MARY LEACH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ARMY I W W I				16. SOCIAL SECURITY NO.			
17. INFORMANT HOSPITAL RECORD				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Cardiac Failure DUE TO (c) Heart Disease - Rheumatic INTERVAL BETWEEN ONSET AND DEATH 14 days one week 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-14-57 , 19 57 , to 12-28 , 19 57 , that I last saw the deceased alive on 12-27- , 19 57 , and that death occurred at 4:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Hare				ADDRESS (Street, city or town, state) Takoma Park, Md			
PHYSICIAN'S NAME (Type) Robert A. HARE				DATE SIGNED 12/28/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines				24a. REC'D BY REGISTRAR CO-2901-14 ST. N.W. Wash., D.C.			
24b. REGISTRAR'S SIGNATURE DEC 30 1957				24c. REGISTRAR'S SIGNATURE W. L. H. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Page 1 of 1

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF CEMETERY</p>	
<p>19. SIGNATURE OF CHURCH</p>		<p>20. SIGNATURE OF MINISTERS</p>	
<p>21. SIGNATURE OF OTHER</p>		<p>22. SIGNATURE OF OTHER</p>	
<p>23. SIGNATURE OF OTHER</p>		<p>24. SIGNATURE OF OTHER</p>	
<p>25. SIGNATURE OF OTHER</p>		<p>26. SIGNATURE OF OTHER</p>	
<p>27. SIGNATURE OF OTHER</p>		<p>28. SIGNATURE OF OTHER</p>	
<p>29. SIGNATURE OF OTHER</p>		<p>30. SIGNATURE OF OTHER</p>	
<p>31. SIGNATURE OF OTHER</p>		<p>32. SIGNATURE OF OTHER</p>	
<p>33. SIGNATURE OF OTHER</p>		<p>34. SIGNATURE OF OTHER</p>	
<p>35. SIGNATURE OF OTHER</p>		<p>36. SIGNATURE OF OTHER</p>	
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<p>41. SIGNATURE OF OTHER</p>		<p>42. SIGNATURE OF OTHER</p>	
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<p>45. SIGNATURE OF OTHER</p>		<p>46. SIGNATURE OF OTHER</p>	
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<p>49. SIGNATURE OF OTHER</p>		<p>50. SIGNATURE OF OTHER</p>	
<p>51. SIGNATURE OF OTHER</p>		<p>52. SIGNATURE OF OTHER</p>	
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<p>65. SIGNATURE OF OTHER</p>		<p>66. SIGNATURE OF OTHER</p>	
<p>67. SIGNATURE OF OTHER</p>		<p>68. SIGNATURE OF OTHER</p>	
<p>69. SIGNATURE OF OTHER</p>		<p>70. SIGNATURE OF OTHER</p>	
<p>71. SIGNATURE OF OTHER</p>		<p>72. SIGNATURE OF OTHER</p>	
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<p>77. SIGNATURE OF OTHER</p>		<p>78. SIGNATURE OF OTHER</p>	
<p>79. SIGNATURE OF OTHER</p>		<p>80. SIGNATURE OF OTHER</p>	
<p>81. SIGNATURE OF OTHER</p>		<p>82. SIGNATURE OF OTHER</p>	
<p>83. SIGNATURE OF OTHER</p>		<p>84. SIGNATURE OF OTHER</p>	
<p>85. SIGNATURE OF OTHER</p>		<p>86. SIGNATURE OF OTHER</p>	
<p>87. SIGNATURE OF OTHER</p>		<p>88. SIGNATURE OF OTHER</p>	
<p>89. SIGNATURE OF OTHER</p>		<p>90. SIGNATURE OF OTHER</p>	
<p>91. SIGNATURE OF OTHER</p>		<p>92. SIGNATURE OF OTHER</p>	
<p>93. SIGNATURE OF OTHER</p>		<p>94. SIGNATURE OF OTHER</p>	
<p>95. SIGNATURE OF OTHER</p>		<p>96. SIGNATURE OF OTHER</p>	
<p>97. SIGNATURE OF OTHER</p>		<p>98. SIGNATURE OF OTHER</p>	
<p>99. SIGNATURE OF OTHER</p>		<p>100. SIGNATURE OF OTHER</p>	

BUREAU V. 3

DEC 30 1957

RECEIVED

b. COUNTY

16 x 22

• IS RESIDENCE ON A FARM?
YES ☐ NO ☒

Years

1957

IF UNDER 24 HRS.

Months	Days	Hours	Min.
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U.S.

Mary MILLER

(Wife) Carolyn M. URBAN (Same As #2)

INTERVAL BETWEEN ONSET AND DEATH

(b) Pulmonary Edema, ATRIAL fibrillation
DUE TO (c) Diffuse Cerebro-Vascular Disease

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

(State)

DATE SIGNED _____

M.D. U.S. Naval Hospital, Bethesda, Md. 12-16-57

U.S. Naval Hospital, Bethesda, Md.

(Sole)

Arlington, Virginia

24b REGISTRAR'S SIGNATURE

DATE 12-16-57

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. BROWN		65		M		W		JAN 15 1957		BATHING	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
123 MAIN ST. BATHING		FARMER		HEART DISEASE		NATURAL		1000		YES	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SINGLE		MARRIED	
JAN 1 1957		MAINE		HIGH SCHOOL		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
JAN 15 1957		BATHING		HEART DISEASE		NATURAL		1000		YES	

BUREAU V. S.

DEC 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13405

13399

Items 11 & 14 G224 1/8/58 GTE

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery M 51				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 12 hr. 30 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. STREET ADDRESS 4314 King Street,			
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Harold		First (nmn)		Middle VAN HOOSE		Last	
4. DATE OF DEATH December		Month 17		Day 19		Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 November 1910	9. AGE (In years lost birthday) 47 yrs.	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 17	Hours 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Government		10b. KIND OF BUSINESS OR INDUSTRY State Department		11. BIRTHPLACE (State or foreign country) Pennsylvania Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George VAN HOOSE				14. MOTHER'S MAIDEN NAME Mary (last name unknown) Mary Witten			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-II		17. INFORMANT (Wife) Sadie M. VAN HOOSE		Address (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, subarachnoid DUE TO Hypertension arterial, benign Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hypertensive vascular disease, benign 330 X 22 hrs 7 years						INTERVAL BETWEEN ONSET AND DEATH 22 hrs 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 December, 19 57 , to 17 December, 19 57 , that I last saw the deceased alive on 16 December, 19 57 , and that death occurred at 12:30 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.				DATE SIGNED 12-17-57			
ACTUAL SIGNATURE W. B. Ingram				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) W. B. INGRAM, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-57		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Portsmouth, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-17-57	
24b. REGISTRAR'S SIGNATURE Mary E. Connelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DEC 28 1957

RECEIVED

13406

CERTIFICATE OF DEATH

13400

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 65 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Walter Last Vuncannon				4. DATE OF DEATH Month December Day 1 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1870		9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Lumberman		10b. KIND OF BUSINESS OR INDUSTRY So. Pine Lumber		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. H. Vuncannon				14. MOTHER'S MAIDEN NAME Martha E. Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Martha Reixach-Item # 2		17. INFORMANT Address Martha Reixach-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Plum Effusion + Cardio Vascular collapse 179x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma - Prostate. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 21 , 19 57 , to Dec 1 , 19 57 , that I last saw the deceased alive on 12-1 , 19 57 , and that death occurred at 5:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. F. Luckett				ADDRESS (Street, city or town, state) 5000 Reno Rd Md		DATE SIGNED 12-1-57	
PHYSICIAN'S NAME (Type) Wm. F. Luckett							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur.-Tran.		22b. DATE THEREOF 12/2/57		22c. NAME OF CEMETERY OR CREMATORY St. John Cem.		22d. LOCATION (City, town, or county) (State) Orleans Parish-La.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 12-2-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 show the certificate forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13401
214

13407

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		d. STREET ADDRESS <u>10,705 Lockridge Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10,705 Lockridge Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMILIE</u> Middle <u>(nmi)</u> Last <u>WAGEN</u>		4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/20/80</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Switzerland</u>	
13. FATHER'S NAME <u>Jacob Hultegger</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Leeman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Walter W. Albersheim, Silver Spring, Md.</u>		Address <u>10,705 Lockridge Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized encephalopathy</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis & Hypertension</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>One month</u> <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart, MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>December 31, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Dec. 31, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 6 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

FOR STATE
HEALTH DEPT.

1

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(1)

NOTE

BUREAU V. S.

JAN 6 1958

RECEIVED

DEC 31 1957

13408

CERTIFICATE OF DEATH

13402

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md. (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lovett (Cumberland) 01x2.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NMMC, Bethesda, Md.				d. STREET ADDRESS 439 Walnut Street			
3. NAME OF DECEASED (Type or print) First James Middle Thompson Last WALKER				4. DATE OF DEATH Month December Day 31 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 February 1902	
9. AGE (In years lost birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marines				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME James WALKER				14. MOTHER'S MAIDEN NAME Bessie BROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Brother) Robert Burns Walker Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction, myocardium #4701 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) 420.1 DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 December, 19 57 to 31 December, 19 57 , that I last saw the deceased alive on 31 December 19 57 and that death occurred at 11:50A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C.U. Shilling M.D. U.S. Naval Hospital, Bethesda, Md. 1-2-58							
ACTUAL SIGNATURE C.U. Shilling PHYSICIAN'S NAME (Type) C.U. Shilling LT MC USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/57		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Right Funeral Home, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE 31 Dec 57 24b. REGISTRAR'S SIGNATURE Mary E. Casselly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED (Print name in full) _____</p>		<p>2. SEX (Print sex) _____</p>	
<p>3. AGE (Print age) _____</p>		<p>4. DATE OF BIRTH (Print date) _____</p>	
<p>5. PLACE OF BIRTH (Print place) _____</p>		<p>6. OCCUPATION (Print occupation) _____</p>	
<p>7. MARITAL STATUS (Print status) _____</p>		<p>8. CAUSE OF DEATH (Print cause) _____</p>	
<p>9. MEDICAL HISTORY (Print history) _____</p>		<p>10. SIGNATURE OF PHYSICIAN (Print signature) _____</p>	
<p>11. SIGNATURE OF WITNESS (Print signature) _____</p>		<p>12. SIGNATURE OF DECEASED (Print signature) _____</p>	
<p>13. SIGNATURE OF FUNERAL HOME (Print signature) _____</p>		<p>14. SIGNATURE OF HEALTH DEPARTMENT (Print signature) _____</p>	

BUREAU V. S.

JAN 6 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13409 CERTIFICATE OF DEATH

13403

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home				d. STREET ADDRESS 9909 Thornwood Road			
3. NAME OF DECEASED (Type or print) CLARE E. WARENDORFF				4. DATE OF DEATH Dec. 2, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 14, 1878	
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 3 Days 18		IF UNDER 24 HRS. Hours 18 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist-Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Paul Karge				14. MOTHER'S MAIDEN NAME Elizabeth Mertens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Walter P Warendorff same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x DUE TO Central Pneumonia and Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. } (b) Anterolateral Ventricular (c) Myocardial Infarction						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1955 , 19____, to 12/2/57 , 19____, that I last saw the deceased alive on 12/2/57 , 19____, and that death occurred at 10:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10403 Fawcett, St. Kensington DATE SIGNED ACTUAL SIGNATURE Samuel Allen M.D. 10403 Fawcett, St. Kensington PHYSICIAN'S NAME (Type) SAMUEL ALLEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/6/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				24a. REC'D BY REGISTRAR Bessie M. Thompson		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		SOCIAL HISTORY	
HISTORICAL DATA		PHYSICAL DATA	
LABORATORY DATA		RADIOLOGICAL DATA	
PATHOLOGICAL DATA		CLINICAL DATA	
MICROSCOPIC DATA		HISTOCHEMICAL DATA	
IMMUNOLOGICAL DATA		GENETIC DATA	
ANTHROPOLOGICAL DATA		LINGUISTIC DATA	
PSYCHOLOGICAL DATA		SOCIOLOGICAL DATA	
ECONOMIC DATA		CULTURAL DATA	
LEGAL DATA		ETHNIC DATA	
RELIGIOUS DATA		POLITICAL DATA	
MILITARY DATA		ACADEMIC DATA	
PROFESSIONAL DATA		ARTISTIC DATA	
SPORTS DATA		RECREATIONAL DATA	
HOBBIEST DATA		PASTIMES DATA	
FAMILY DATA		FRIENDS DATA	
COMMUNITY DATA		CITY DATA	
STATE DATA		NATIONAL DATA	
INTERNATIONAL DATA		GLOBAL DATA	

BUREAU V. 1

DEC 5 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3226 Highwood Drive, S.E.			
3. NAME OF DECEASED (Type or print) First Lillian Middle Carlene Last Warfield				4. DATE OF DEATH Month December Day 31 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1902		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 55	IF UNDER 24 HRS. Days 31 Hours 19 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing Profession		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Warfield				14. MOTHER'S MAIDEN NAME Anna Farmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Embolism DUE TO Thrombophlebitis, left iliac and femoral veins Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 464X DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Glioblastoma Multiforme							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 12, 19 57 , to December 31, 19 57 , that I last saw the deceased alive on December 31, 19 57 , and that death occurred at 8:20a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/31/57 ACTUAL SIGNATURE PETER T. ROWLEY M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) PETER T. ROWLEY, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Dec. 3, 1958		Cedar Hill		Smithland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John W. Jones				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR DATE 6 1958	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

Use this form

Signature of Physician

Signature

Signature

Signature of Physician

Signature

Signature

Signature of Physician

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Signature of Physician

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BUREAU V. S.

JAN 6 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13411

CERTIFICATE OF DEATH

13405
Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 22 Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home				d. STREET ADDRESS 4504 Harlen Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WALTER D. WARREN, Sr.				4. DATE OF DEATH Month Day Year Dec. 25 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1869		9. AGE (In years last birthday) yrs. 88	IF UNDER 1 YEAR Months Days Hours Min. 1 9	IF UNDER 24 HRS. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Civil Engineer		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Warren				14. MOTHER'S MAIDEN NAME Rebecca Gates			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Walter D. Warren, Jr. - Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarct 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. ft. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 56 , to Dec , 19 57 , that I last saw the deceased alive on 23 Dec , 19 57 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert Martyn Jr. M.D.				ADDRESS (Street, city or town, state) 5029 Bethesda Ave.			
PHYSICIAN'S NAME (Type) HERBERT MARTYN JR.				DATE SIGNED 25 Dec 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Trans		22b. DATE THEREOF 12/28/57		22c. NAME OF CEMETERY OR CREMATORY Newton		22d. LOCATION (City, town, or county) (State) Newton, Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 12-27-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE		DATE OF DEATH JAN 10 1957	
NAME OF DECEASED WALTER D. WARREN		SEX MALE	
AGE 48		RACE WHITE	
PLACE OF BIRTH BALTIMORE, MARYLAND		PLACE OF DEATH BALTIMORE, MARYLAND	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
TIME OF DEATH 10:00 AM		PLACE OF INTERMENT BALTIMORE	
SIGNATURE OF DECEASED (Signature)		SIGNATURE OF WITNESS (Signature)	
SIGNATURE OF PHYSICIAN (Signature)		SIGNATURE OF CORONER (Signature)	

BUREAU V. B

JEC 80 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13412 CERTIFICATE OF DEATH

Reg. Dist. No.

134068
298

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>			c. LENGTH OF STAY IN 1b <u>X2</u> <u>Germantown</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2</u> <u>Germantown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lilah</u> Middle <u>Washington</u> Last <u>Washington</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15, 1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Fairfax</u>				14. MOTHER'S MAIDEN NAME <u>Maria Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles Washington</u> <u>Germantown, Maryland</u>			
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>55</u> , to <u>Dec. 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 4</u> , 19 <u>57</u> , and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Vernon E. Martens</u> M.D., <u>Germantown, Md.</u>				<u>12-5-57</u>			
PHYSICIAN'S NAME (Type) <u>Vernon E. Martens</u>				<u>M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 11 1957</u>	
				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MEDICAL HISTORY [Illegible]		SURVIVAL [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]	

BUREAU V. S.

DEC 11 1957

RECEIVED

MARYLAND-STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13413

CERTIFICATE OF DEATH

13407

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown c. LENGTH OF STAY IN 1b - d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marylander		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown x2 d. STREET ADDRESS Waters Road 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY ELEANOR CISELL WATERS First Middle Last		4. DATE OF DEATH Dec. 19, 1957 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1887 9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Humphrey Cissell	
14. MOTHER'S MAIDEN NAME Julia Griffith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Ella V. Gochenour-Germantown, Md. Address Waters Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Pulmonary Edema DUE TO (b) Myocardial Infarction DUE TO (c) Coronary Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 hours 1 day 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1950 , to Dec 1957 , that I last saw the deceased alive on Dec 19 1957 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Germantown DATE SIGNED Robert A. Pumphrey			
ACTUAL SIGNATURE V.E. Mathias M.D. Germantown			
PHYSICIAN'S NAME (Type) V.E. Mathias			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/21/57	22c. NAME OF CEMETERY OR CREMATORY Neelsville Ch. Cem.	22d. LOCATION (City, town, or county) (State) Neelsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DEL 23 1957	24b. REGISTRAR'S SIGNATURE Alberda Cooke

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 23 1957

RECEIVED

BUREAU V. B.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—FACILITY ONE 13

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13414 CERTIFICATE OF DEATH

13409

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE District of Columbia b. COUNTY Washington <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 80 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3239 P Street, N.W.			
3. NAME OF DECEASED (Type or print) First Leslie Middle Allyne Last Wells				4. DATE OF DEATH Month December Day 20 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 29, 1901	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer				10b. KIND OF BUSINESS OR INDUSTRY Photographing		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Delbert M. Wells				14. MOTHER'S MAIDEN NAME Annette Boswell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 181-10-1828		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS DUE TO 180X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) METASTATIC RENAL CELL CARCINOMA DUE TO 2 1/2 YEARS (c) CARCINOMA OF RIGHT KIDNEY DUE TO 2 1/2 YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUODENAL ULCER							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from October 1, 1957 , to December 20, 1957 , that I last saw the deceased alive on December 20, 1957 , and that death occurred at 11:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12-20-57 ACTUAL SIGNATURE Richard K. Shaw M.D. M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Richard K. Shaw, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/57		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's son				24a. REC'D BY REGISTRAR DEC 26 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Amanda Ward Whelan		4. DATE OF DEATH Month Dec. Day 17 Year 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1888
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas G. Ward		14. MOTHER'S MAIDEN NAME Martha V. Whalen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) #### (If yes, give date of service) ####		16. SOCIAL SECURITY NO. None	
17. INFORMANT George T. Whalen,		Address Derwood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Hypertensive Cardiorenal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Sclerosis with Senile Dementia.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 4, 1957 to Dec. 17, 1957 , that I last saw the deceased alive on Dec. 17, 1957 , and that death occurred at 12:07 P. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Nrobeck Rt. 1, Silver Spring, Md.	
ACTUAL SIGNATURE Webster Sewell M.D.		DATE SIGNED 12/18/57	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 20 57	
22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Abner L. Cook	

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CERTIFICATE OF DEATH

1341118

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quince Orchard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quince Orchard</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gaithersburg, R. F. D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>WHITE</u> Last <u>WHITE</u>		4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>74</u> Days <u>74</u> Hours <u>74</u> Min. <u>74</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>John White</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Bacon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Mrs Sarah White, Gaithersburg, Md.</u>	
17. INFORMANT <u>Mrs Sarah White, Gaithersburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>2 months</u> 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> to <u>Dec. 27, 1957</u> , that I last saw the deceased alive on <u>Dec. 27, 1957</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. R. Foulthum</u> M.D.		DATE SIGNED <u>12/27/57</u>	
PHYSICIAN'S NAME (Type) <u>26 N. Summit Ave., Gaithersburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View</u>		22d. LOCATION (City, town, or county) (State) <u>Quince Orchard, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Szwed</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 2 1958</u>	
		24b. REGISTRAR'S SIGNATURE <u>Alfred G. Cook</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13287

CERTIFICATE OF DEATH

Reg. Dist. No. 13412
773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>		d. STREET ADDRESS <u>2405 Dennis Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Augustine</u> Last <u>Wilkinson</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/17/04</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>		IF UNDER 24 HRS. Hours <u>11</u> Min. <u>11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Claims Adjuster</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Acct. Office</u>		11. BIRTHPLACE (State or foreign country) <u>N. Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Stephen Wilkinson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Minnock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Wife</u> Address <u>same as above.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> 420.0 DUE TO <u>Recurrent myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO <u>Myocardial infarction</u> (c) <u>5 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , 19____, to <u>12/11/57</u> , 19____, that I last saw the deceased alive on <u>12/11/57</u> , 19____, and that death occurred at <u>8:30 p.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>900-12th St. N. Wash. D.C.</u> DATE SIGNED <u>12/11/57</u> ACTUAL SIGNATURE <u>Bernard L. Walsh</u> M.D. PHYSICIAN'S NAME (Type) <u>Bernard L. Walsh</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 16 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF CHURCH OFFICIAL</p>	
<p>19. SIGNATURE OF CEMETERY OFFICIAL</p>		<p>20. SIGNATURE OF OTHER OFFICIAL</p>	

BUREAU V. S.

DEC 16 1957

RECEIVED

CERTIFICATE OF DEATH

Items 2 & 4, Film G-224 1/3/50 sac

Reg. Dist. No.

13413

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE New York MARYLAND b. COUNTY KINGS PARK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON Kings Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4120 Wexford Court				d. STREET ADDRESS Home T. State Hospital 4120 Wexford Court			
3. NAME OF DECEASED (Type or print) First LEON Middle R. Last WILLIAMS				4. DATE OF DEATH Month Dec. Day 9, 1957 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 29 Oct. 1895	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas R. Williams				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.I. 128-05-310		17. INFORMANT Maj (Ar.) Williams		Address 4120 Wexford Ct.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident, thrombosis DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular Arteriosclerosis & insufficiency DUE TO unknown (c) _____							INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease with myocardial infarction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 October , 19 57 , to 9 December , 19 57 , that I last saw the deceased alive on 8 December , 19 57 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard F. Clowdus M.D.				ADDRESS (Street, city or town, state) 1100 th USAF Hospital DATE SIGNED _____			
PHYSICIAN'S NAME (Type) BERNARD F. CLOWDUS, M.D.				Bolling AFB, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/12/57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l		22d. LOCATION (City, town, or county) (State) Ft. Myer Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. ADDRESS 3072 14th St NW Wash DC				24a. REC'D BY REGISTRAR DEC 10 1957		24b. REGISTRAR'S SIGNATURE Frances P. Lister	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE IN CASE A. DATE OF DEATH		B. PLACE OF DEATH	
C. SEX		D. AGE	
E. RACE		F. OCCUPATION	
G. MARITAL STATUS		H. CAUSE OF DEATH	
I. MANNER OF DEATH		J. PLACE OF BIRTH	
K. DATE OF BIRTH		L. DATE OF DEATH	
M. NAME OF DECEASED		N. NAME OF PHYSICIAN	
O. NAME OF FUNERAL HOME		P. NAME OF BURIAL PLACE	
Q. NAME OF WITNESS		R. NAME OF REGISTRAR	
S. NAME OF CLERK		T. NAME OF ASSISTANT	
U. NAME OF NURSE		V. NAME OF CHAPLAIN	
W. NAME OF MINISTER		X. NAME OF RABBI	
Y. NAME OF PRIEST		Z. NAME OF OTHER	

BUREAU V. S.

DEC 10 1957

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13414

13418

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Kensington</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WESTMORELAND HILLS</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Keningston Gardens Sanitarium</u>				STREET ADDRESS (If rural give location) <u>5210 ARLINGTON ROAD</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>HARRY</u> (Middle) <u>L.</u> (Last) <u>WILLIAMSON</u>				(Month) <u>Dec.</u> (Day) <u>19</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Nov. 19, 1884</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Insurance</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Henry Williamson</u>				14. MOTHER'S MAIDEN NAME <u>Louise Ebelhere</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Lindell Leathers</u> <u>5210 Arlington Rd. Washington D.C.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>420.0 Congestive Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9/11/57</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/11</u> , 19 <u>57</u> , to <u>12/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/30</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Aris Carpanis</u>				ADDRESS (Street, city, town, state) <u>2801 Wisconsin Ave NW DC</u>		DATE SIGNED <u>12/20/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Dec. 20, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Warm Springs Cemetery</u>		LOCATION (City, town, or county) (State) <u>Warm Springs, Va.</u>	
24. REC'D BY REGISTRAR <u>12-21-57</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ives Funeral Home C. M. Ives</u> <u>2847 Wilson Blvd., Arlington, Va.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1. FULL NAME OF DECEASED

2. SEX

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. OCCUPATION

6. MARITAL STATUS

7. COLOR

8. RELIGION

9. PRESENT ADDRESS

10. DATE OF DEATH

11. PLACE OF DEATH

12. CAUSE OF DEATH

13. MEDICAL HISTORY

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF WITNESS

17. SIGNATURE OF DECEASED

18. SIGNATURE OF NEXT OF KIN

19. SIGNATURE OF CLERK

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF CONSTABLE

23. SIGNATURE OF JURY

24. SIGNATURE OF GRAND JURY

25. SIGNATURE OF DISTRICT CLERK

26. SIGNATURE OF COUNTY CLERK

27. SIGNATURE OF CITY CLERK

28. SIGNATURE OF TOWNSHIP CLERK

29. SIGNATURE OF VILLAGE CLERK

30. SIGNATURE OF POST OFFICE CLERK

31. SIGNATURE OF SCHOOL CLERK

32. SIGNATURE OF CHURCH CLERK

33. SIGNATURE OF SYNAGOGUE CLERK

34. SIGNATURE OF MOSQUE CLERK

35. SIGNATURE OF TEMPLE CLERK

36. SIGNATURE OF MONASTERY CLERK

37. SIGNATURE OF CONVENT CLERK

38. SIGNATURE OF NUN CLERK

39. SIGNATURE OF PRIEST CLERK

40. SIGNATURE OF BISHOP CLERK

41. SIGNATURE OF CARDINAL CLERK

42. SIGNATURE OF DEACON CLERK

43. SIGNATURE OF MONK CLERK

44. SIGNATURE OF NUN CLERK

45. SIGNATURE OF PRIEST CLERK

46. SIGNATURE OF BISHOP CLERK

47. SIGNATURE OF CARDINAL CLERK

48. SIGNATURE OF DEACON CLERK

49. SIGNATURE OF MONK CLERK

50. SIGNATURE OF NUN CLERK

51. SIGNATURE OF PRIEST CLERK

52. SIGNATURE OF BISHOP CLERK

53. SIGNATURE OF CARDINAL CLERK

54. SIGNATURE OF DEACON CLERK

55. SIGNATURE OF MONK CLERK

56. SIGNATURE OF NUN CLERK

57. SIGNATURE OF PRIEST CLERK

58. SIGNATURE OF BISHOP CLERK

59. SIGNATURE OF CARDINAL CLERK

60. SIGNATURE OF DEACON CLERK

61. SIGNATURE OF MONK CLERK

62. SIGNATURE OF NUN CLERK

BUREAU V. 2

DEC 27 1957

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13288

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9913 Woodburn Rd. Silver Spring, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>Takoma Park</u>			
3. NAME OF DECEASED (Type or print) <u>Mr. Robert Karl Wilson</u>				4. DATE OF DEATH <u>December 4</u> 19 <u>57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 9-1905</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Display</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hecht Company</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert P. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Melissa Gale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mrs. Cora S. Wilson, 9913 Woodburn Rd. Silver Spring, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Thrombosis</u> 3 wks 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio Sclerotic CardioVascular dis.</u> 10 yrs DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X Bronchopneumonia, Oct. 1957</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 10</u> , 19 <u>57</u> , to <u>Dec 4</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>Dec 4</u> , 19 <u>57</u> , and that death occurred at <u>4:57</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. B. Orleans</u>				ADDRESS (Street, city or town, state) <u>9500 Colesville Rd Silver Spring Md</u>			
DATE SIGNED <u>DEC 6 1957</u>							
PHYSICIAN'S NAME (Type) <u>H. B. ORLEANS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>Silver Spring Md.</u>			
24a. REC'D BY REGISTRAR <u>J. Wilson</u>				24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES A. WILSON		45		M		W		1892		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		COUNTY	
Carpenter		High School		Married		Roman Catholic		Heart Disease		Natural		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
1957		10:00 AM		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		1957		10:00 AM		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. A. Wilson		J. A. Wilson		J. A. Wilson		J. A. Wilson		J. A. Wilson		J. A. Wilson		J. A. Wilson		J. A. Wilson		J. A. Wilson	

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DEC 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13419

CERTIFICATE OF DEATH

13417216
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Dinwiddie			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 92 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle LEWIS Last Wood				4. DATE OF DEATH Month December Day 25 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 7, 1907	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Ashton Lewis		14. MOTHER'S MAIDEN NAME Mattie Alley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 225-42-8272		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral hydrothorax DUE TO (c) Leiomyosarcoma, metastatic		INTERVAL BETWEEN ONSET AND DEATH 2 wks. 2 wks. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Year 1957 Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September 24, 1957 , to December 25, 1957 , that I last saw the deceased alive on December 25, 1957 , and that death occurred at 1:15 A M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center				DATE SIGNED 12/25/57			
ACTUAL SIGNATURE Kurt W. Kohn, M.D.				M.D. The National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) KURT W. KOHN, M. D.							
22a. BURIAL, CREMATION, or other disposition Burial		22b. DATE THEREOF Dec 27, 1957		22c. NAME OF CEMETERY OR CREMATORY HOME CHURCH CEMETERY		22d. LOCATION (City, town, or county) (State) FORD, DINWIDDIE COUNTY, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Reenie Thompson				24. REC'D BY REGISTRAR DEC 27 1957			
ADDRESS 2540 Carroll St NW				24b. REGISTRAR'S SIGNATURE Reenie Thompson			

CERTIFICATE OF DEATH

MAKING STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

<p>1. Name of deceased: John Lewis</p>		<p>2. Sex: Male</p>		<p>3. Race: White</p>		<p>4. Date of birth: September 1, 1907</p>		<p>5. Place of birth: Virginia</p>		<p>6. Usual residence: Home</p>		<p>7. Cause of death: Heart Disease</p>		<p>8. Duration of illness: 3 days</p>		<p>9. Place of death: The Clinical Center, Baltimore, Md.</p>		<p>10. Signature of physician: John Lewis</p>		<p>11. Signature of registrar: John Lewis</p>	
<p>12. Name of attending physician: John Lewis</p>		<p>13. Name of hospital: The Clinical Center</p>		<p>14. Name of city: Baltimore</p>		<p>15. Name of state: Md.</p>		<p>16. Name of county: Baltimore</p>		<p>17. Name of district: Home</p>		<p>18. Name of ward: Home</p>		<p>19. Name of room: Home</p>		<p>20. Name of bed: Home</p>		<p>21. Name of patient: John Lewis</p>		<p>22. Name of nurse: John Lewis</p>	
<p>23. Name of doctor: John Lewis</p>		<p>24. Name of nurse: John Lewis</p>		<p>25. Name of attendant: John Lewis</p>		<p>26. Name of janitor: John Lewis</p>		<p>27. Name of porter: John Lewis</p>		<p>28. Name of cook: John Lewis</p>		<p>29. Name of steward: John Lewis</p>		<p>30. Name of waiter: John Lewis</p>		<p>31. Name of messenger: John Lewis</p>		<p>32. Name of clerk: John Lewis</p>		<p>33. Name of stenographer: John Lewis</p>	
<p>34. Name of typewriter: John Lewis</p>		<p>35. Name of telephone: John Lewis</p>		<p>36. Name of radio: John Lewis</p>		<p>37. Name of television: John Lewis</p>		<p>38. Name of refrigerator: John Lewis</p>		<p>39. Name of stove: John Lewis</p>		<p>40. Name of sink: John Lewis</p>		<p>41. Name of bathtub: John Lewis</p>		<p>42. Name of toilet: John Lewis</p>		<p>43. Name of bed: John Lewis</p>		<p>44. Name of chair: John Lewis</p>	
<p>45. Name of table: John Lewis</p>		<p>46. Name of desk: John Lewis</p>		<p>47. Name of cabinet: John Lewis</p>		<p>48. Name of wardrobe: John Lewis</p>		<p>49. Name of closet: John Lewis</p>		<p>50. Name of hallway: John Lewis</p>		<p>51. Name of bathroom: John Lewis</p>		<p>52. Name of kitchen: John Lewis</p>		<p>53. Name of living room: John Lewis</p>		<p>54. Name of bedroom: John Lewis</p>		<p>55. Name of porch: John Lewis</p>	
<p>56. Name of garage: John Lewis</p>		<p>57. Name of driveway: John Lewis</p>		<p>58. Name of street: John Lewis</p>		<p>59. Name of city: John Lewis</p>		<p>60. Name of state: John Lewis</p>		<p>61. Name of county: John Lewis</p>		<p>62. Name of district: John Lewis</p>		<p>63. Name of ward: John Lewis</p>		<p>64. Name of room: John Lewis</p>		<p>65. Name of bed: John Lewis</p>		<p>66. Name of patient: John Lewis</p>	
<p>67. Name of nurse: John Lewis</p>		<p>68. Name of attendant: John Lewis</p>		<p>69. Name of janitor: John Lewis</p>		<p>70. Name of porter: John Lewis</p>		<p>71. Name of cook: John Lewis</p>		<p>72. Name of steward: John Lewis</p>		<p>73. Name of waiter: John Lewis</p>		<p>74. Name of messenger: John Lewis</p>		<p>75. Name of clerk: John Lewis</p>		<p>76. Name of stenographer: John Lewis</p>		<p>77. Name of typewriter: John Lewis</p>	
<p>78. Name of telephone: John Lewis</p>		<p>79. Name of radio: John Lewis</p>		<p>80. Name of television: John Lewis</p>		<p>81. Name of refrigerator: John Lewis</p>		<p>82. Name of stove: John Lewis</p>		<p>83. Name of sink: John Lewis</p>		<p>84. Name of bathtub: John Lewis</p>		<p>85. Name of toilet: John Lewis</p>		<p>86. Name of bed: John Lewis</p>		<p>87. Name of chair: John Lewis</p>		<p>88. Name of table: John Lewis</p>	
<p>89. Name of desk: John Lewis</p>		<p>90. Name of cabinet: John Lewis</p>		<p>91. Name of wardrobe: John Lewis</p>		<p>92. Name of closet: John Lewis</p>		<p>93. Name of hallway: John Lewis</p>		<p>94. Name of bathroom: John Lewis</p>		<p>95. Name of kitchen: John Lewis</p>		<p>96. Name of living room: John Lewis</p>		<p>97. Name of bedroom: John Lewis</p>		<p>98. Name of porch: John Lewis</p>		<p>99. Name of garage: John Lewis</p>	
<p>100. Name of driveway: John Lewis</p>		<p>101. Name of street: John Lewis</p>		<p>102. Name of city: John Lewis</p>		<p>103. Name of state: John Lewis</p>		<p>104. Name of county: John Lewis</p>		<p>105. Name of district: John Lewis</p>		<p>106. Name of ward: John Lewis</p>		<p>107. Name of room: John Lewis</p>		<p>108. Name of bed: John Lewis</p>		<p>109. Name of patient: John Lewis</p>		<p>110. Name of nurse: John Lewis</p>	

BUREAU V. 1

DEC 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13289 CERTIFICATE OF DEATH

13418
Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>1005 Houston Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Geraldine</u> Last <u>Wood</u>		4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-83</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Holser</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Steward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>0</u>	
17. INFORMANT <u>Washington Sanitarium and Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonitis, congestive</u> DUE TO <u>non-filling gallbladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Cholecystostomy for cholecystitis and</u> DUE TO <u>Garcinoma of body of pancreas</u> (c) <u>metastatic carcinoma of liver, total</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>11-30-57</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rigid bundle branch block with possible anterolateral infarction</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-24-1957</u> to <u>12-8-1957</u> that I last saw the deceased alive on <u>11-30 P.M. 12-7 1957</u> , and that death occurred at <u>7:07 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Read N. Calvert</u> M.D. <u>7894 Ga. Ave., Silver Spring, Md.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>READ N. CALVERT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Dec 10, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASH. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Riggs Rd., HUNTSVILLE, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Dill</u> ADDRESS <u>2514 ARROLL ST. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>12/12/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Dill</u>			

BUREAU V. 8

DEC 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13420 CERTIFICATE OF DEATH

13419
Reg. Dist. No. 276

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b X0 Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium				d. STREET ADDRESS 4104 East West Highway			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First E Middle Nisbet Last Wright				4. DATE OF DEATH Month December Day 11 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 8, 1873	
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Patrick Henry Wright				14. MOTHER'S MAIDEN NAME Mary Frances Nisbet			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Florence H. Wright, 4104 East West Highway, Chevy Chase, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma right lung with metastasis to left humerus DUE TO (b) to left humerus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 260X (c) INTERVAL BETWEEN ONSET AND DEATH 2 yrs + 3 months.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus 2) Pathologic fracture left humerus No 014 1957							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 29, 1957 , to Dec , 1957, that I last saw the deceased alive on Dec , 1957, and that death occurred at 6:50 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3921 Ingomar St. N.W. Wash 15 D.C. DATE SIGNED							
ACTUAL SIGNATURE Stewart Clapp				M.D. 3921 Ingomar St. N.W. Wash 15 D.C.			
PHYSICIAN'S NAME (Type) Stewart Clapp							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Dec. 13, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Rd., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home 5103 Wisconsin				ADDRESS		24a. REC'D BY REGISTRAR DATE 12-18-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Hornsby			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13421 CERTIFICATE OF DEATH

13420

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>4123 Woodbine St</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>T</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Biologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Young</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Dalzell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert Young (son)</u>		Address <u>Cherry Chase 4123 Woodbine St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Stomach with Hepatic Metastases</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 5</u> , 19 <u>57</u> , to <u>Dec 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 8</u> , 19 <u>57</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut M.D.</u>		<u>4890 Battery Lane, Bethesda Md</u>	
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut M.D.</u>		<u>12/9/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>12-11-57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Deborah M. Thompson</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH, BUREAU OF VITAL RECORDS

BUREAU V. 2

DEC 13 1957

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